The Modern Hospital

JULY 1959

Drug Therapy in the Modern Hospital

Symposium beginning on page 85

Unions and Hospitals

Beginning on page 61

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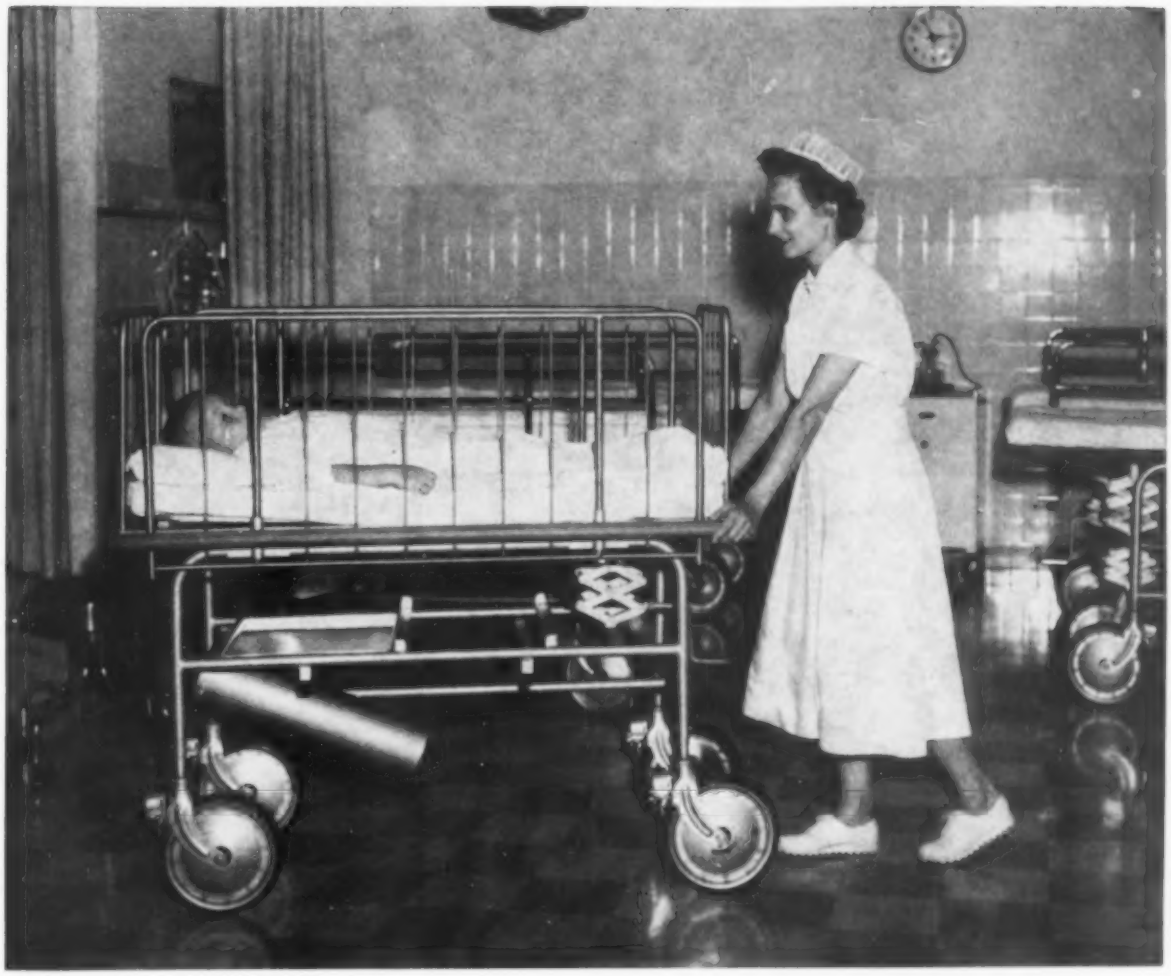

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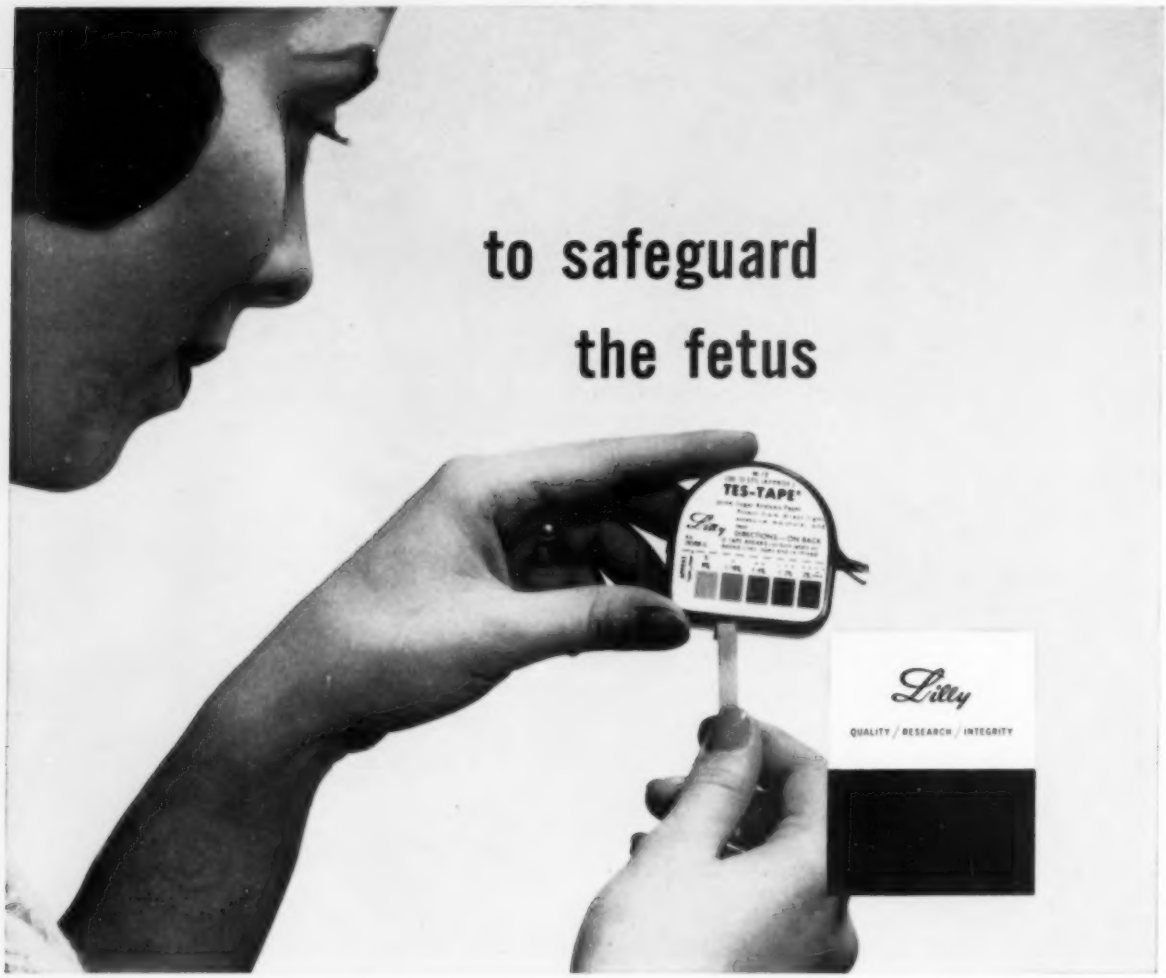

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1. Shlevin, E. L.: Pregnancy and Diabetes, Diabetes, *6*:523, 1957.
2. Wilkerson, H. L. C.: *Ibid.*
3. Whitehouse, F. W., *et al.*: Management of the Pregnant Diabetic, M. Times, *86*:833, 1958.

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The Modern Hospital

JULY 1959 VOLUME 93, NO. 1

Articles in this issue

Continued on next page ▶

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The Modern Hospital

MEDICINE AND PHARMACY

A Pharmacist Views Drug Therapy

Ways in which the hospital pharmacist should take initiative to help solve research, diagnostic and patient care problems are suggested.

Exact Procedures Are a Must To Combat Infection

Operating room garments can be a source of contamination, the author warns, reviewing basic rules regarding them in Operating Room Forum.

FOOD SERVICE

How To Keep Out of Trouble in the Kitchen

Trouble usually starts with bad planning, but careful attention to details of design, materials and location of kitchen equipment can prevent small oversights from becoming major problems.

Cream Sauce Adds Magic to Meals

How to blend in versatility and appeal by adding cream sauce to soups, vegetables, casseroles, meat and fish dishes. Methods of preparation discussed are roux, conventional and a new white sauce base.

MAINTENANCE AND OPERATION

What It Takes To Be a Good Engineer

Good maintenance parallels good management, the author says; to be effective the hospital engineer needs to know how to supervise and delegate as well as how to turn off valves.

REGULAR FEATURES

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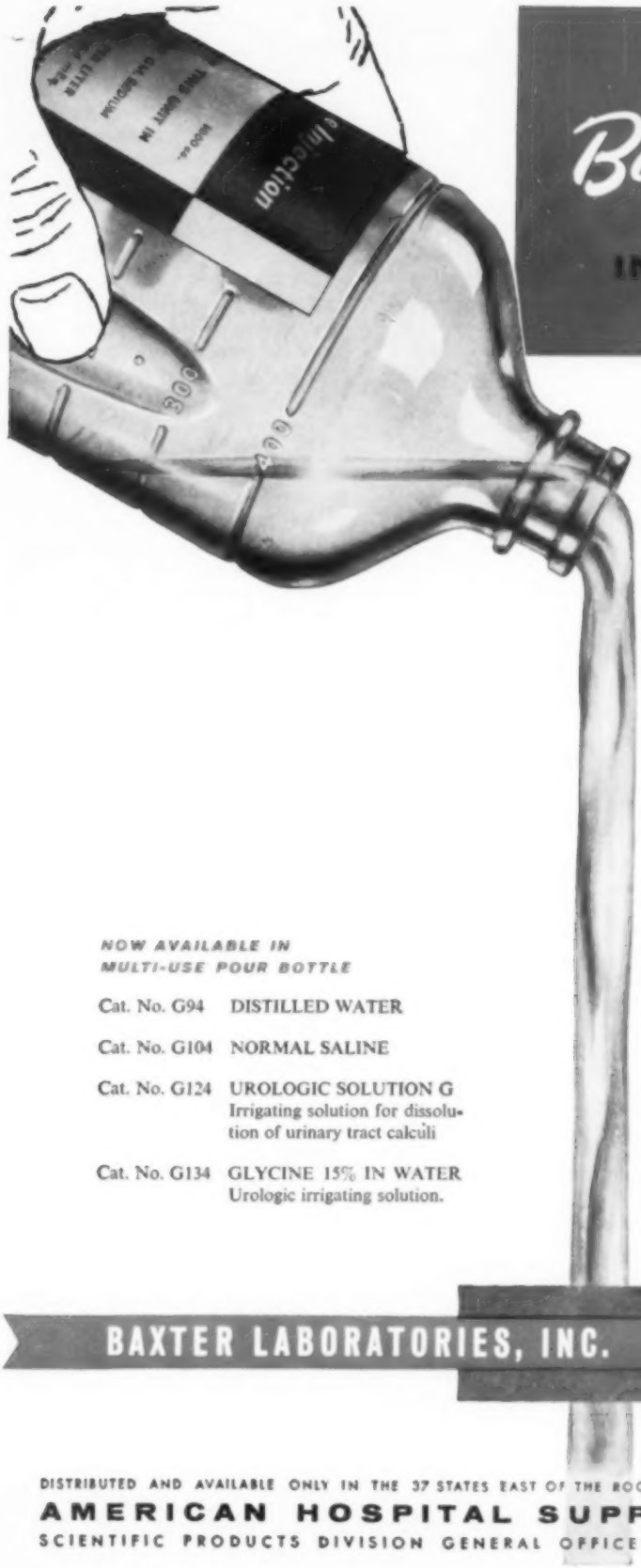

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READER OPINION

Partisanship

Sirs:

I was disappointed in your May 1959 issue of The Modern Hospital — the picture and article, "Morse Takes the Prize for Showmanship."

It smacks of partisanship. Our hospital publications have been so free of partisanship. May they continue to be! I should dislike to see your very fine publication blighted. To me, it is indicative of poor taste and poorer judgment.

An Interested Reader

St. Louis

We are always sorry to disappoint an interested reader — even an anonymous one, and we are embarrassed to be found out in a lapse of taste and a worse lapse of judgment — even when we don't understand what they were. But, for the life of us, we can't figure out whether the offending article was considered pro-Morse or anti-Morse, or whether "Interested Reader" is a Democrat or a Republican. — Ed.

O.P.C. for P.P.C.

Sirs:

Bravo for your articles on Progressive Patient Care! Many of us have long believed in this concept of hospital treatment. In your March issue, the St. Johns Hospital of St. Paul claims to have antedated the Manchester experiment, but it may be maintained that even the St. Johns Hospital plan was preceded by others.

The progressive patient care program in many of our voluntary hospitals was established before the turn of the century. The intensive care unit was called the ward and was arranged so that the nurses' station was in the center of the room. The nurse enjoyed ready observation of all patients because no between-bed curtains obstructed her vision. There was little danger of electrostatically-caused anesthesia explosions, for we used gas lights for illumination. We didn't have to concern ourselves with placement of oxygen outlets because we had none.

The original progressive care programs sustained more than five stages, being truly "tailored to fit the patient's needs." Most of the obstetrics deliveries, for example, were performed under a special home care program. The self-help unit was somewhat casually organized, flourishing particularly in times of nursing shortages.

One of the noteworthy advantages of progressive patient care was that the nurses stayed at the bedside. They seldom left it. And nurses received the job satisfaction of total patient care, for they were able to tidy up the ward, clean the floor p.r.n. without asking housekeeping, serve the patient his meals, and work out social service problems.

Now, with the accouterments of modernity, it may be timely for many of our contemporaries to abandon progressive patient care. Because the advantages of electricity, air conditioning, piped oxygen, and patient privacy are manifest, it may well be that the time has come for us to leave behind such a fine-sounding program as P. P.-C. and to develop a new term: Optimal Patient Care. If we do nothing more for the modern hospital, we ought to run O.P.C. (notice how familiar we are with it already) up the flagpole and see if anyone salutes.

Milton W. Hamilt
Assistant Director

Sinai Hospital
Baltimore

Object to Title

Sirs:

We must say that we have been unhappy about the title, "Development Program for Administrators Teaches Them To Think Like Executives," for our article in the April issue. It doesn't appear to us to represent either the letter or the spirit of the article.

Authors do not select titles for magazine articles and perhaps something catchy is necessary to attract attention, but this one was a little too much so. If we get any brickbats we're going to heave them right in your direction.

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ROVING REPORTER

Boys Also Serve

Among approximately 90 teen-agers who have done volunteer work at Sherman Hospital, Elgin, Ill., during the last year, 15 earned A.H.A. teen-age volunteer service pins for 50 or more hours of service and three of these were boys who have given a total of 368 hours. Three other boys have given some service. Most of the hours were given during the summer vacation, but four volunteers worked during holiday vacations.

Jim Ricketts, who tops the group with 150 volunteer hours in the clinical laboratory, has now been accepted as a regular technician trainee on a part-time basis with the compensation rate paid full-time trainees. He is a sophomore in Elgin High School.

Tom Alltop, whose mother is a volunteer worker as a member of the Sherman Junior Auxiliary, has chalked up 130 hours in the stockroom. Larry Wright divided his 88½ hours of service between working in the stockroom and running the hospital elevators during visiting hours. The hospital has automatic elevators, but it has been found that having a volunteer to run them during busy visiting hours is appreciated by visitors and also speeds transit to the different floors. Both boys are sophomores. — FLORENCE SLOWN HYDE, *public relations counsel, Sherman Hospital.*

Film Prepares Parents

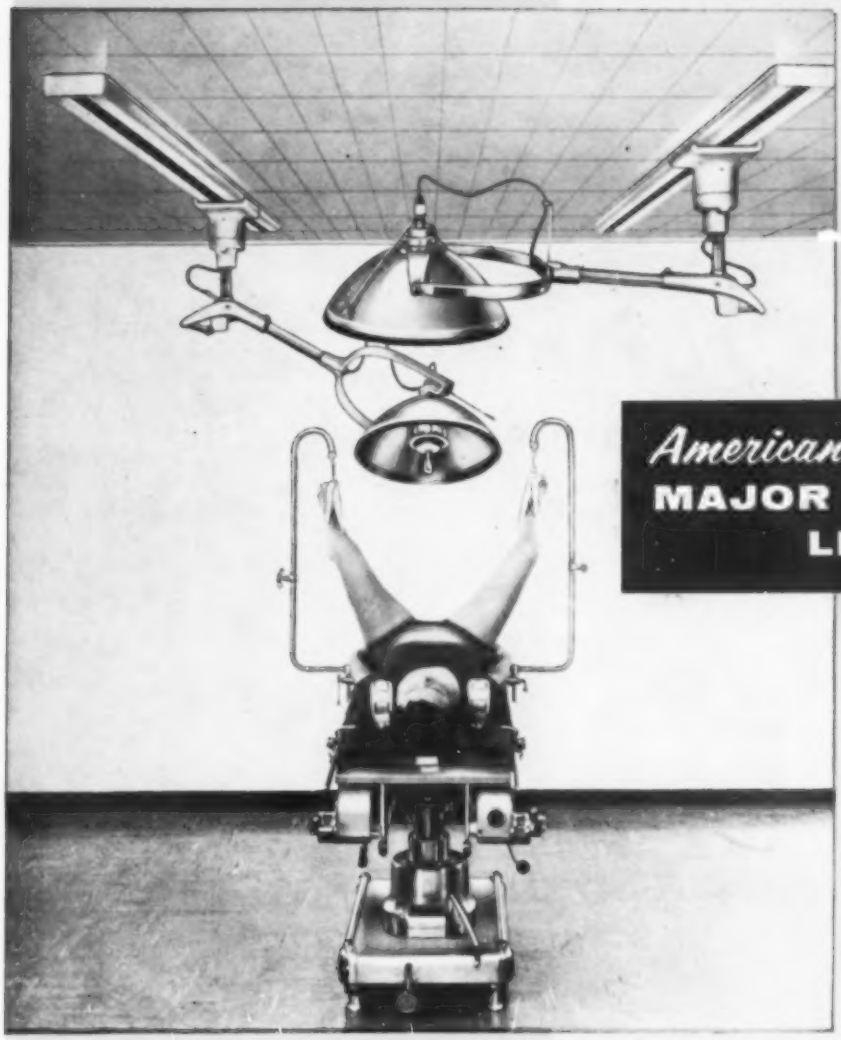
Pioneering a new type of public relations, Mercy Hospital, Bakersfield, Calif., has presented at public showings a story in picture and sound dealing with the birth of a baby. Called "The Magnificent Gift," the picture revolves around a young family preparing for the first baby and takes the viewer through the actual stages before and after the baby's birth.

Produced by the hospital auxiliary, the film is shown at monthly coffees for parents-to-be. The coffees are held in the evening to give fathers a chance to attend. Auxiliary volunteers greet the guests and serve them refreshments before the picture.

Since the hospital's maternity department is restricted for the public, with only fathers of new babies allowed to visit the floor, the film provides a graphic description of the equipment and service available in the hospital. It also answers many questions on the details of hospitalization for first-time mothers.

Parents register for the coffee party and film for prospective parents.

The impact of the film has surprised the auxiliary members, they report. They had anticipated a maximum attendance at any one coffee would be about 25. At the last showing 47 parents were registered.



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Wheel Them to Showers

Bed patients who, for various reasons, are difficult to get in and out of a bath tub, may be given a bath on a hospital type of stretcher, provided it is specially equipped for the comfort of the patient and the preservation of the equipment. This idea, already in successful use, is reported on by the division of hospital services of the Georgia department of public health in its bulletin.

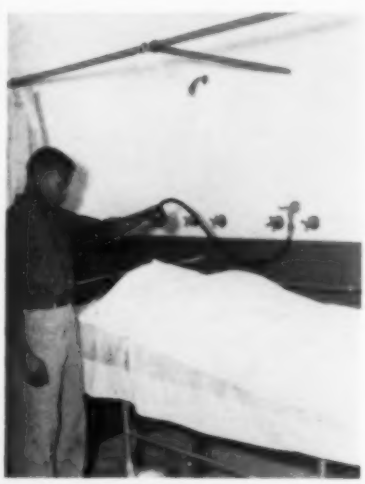
An ordinary wheel stretcher may be used, although the stainless metal ones are best as they will not rust. A stretcher painted with aluminum paint would also be satisfactory, the department reports.

A polyethylene pad 2 inches thick, 22 inches wide and 72 inches long will cover the stretcher adequately and serve as padding. Foam rubber should not be used, the bulletin warns, as it will decay if it gets wet. A rubber or waterproof sheet must be placed over the pad and should hang low enough to prevent water from seeping in under the padding or mattress.

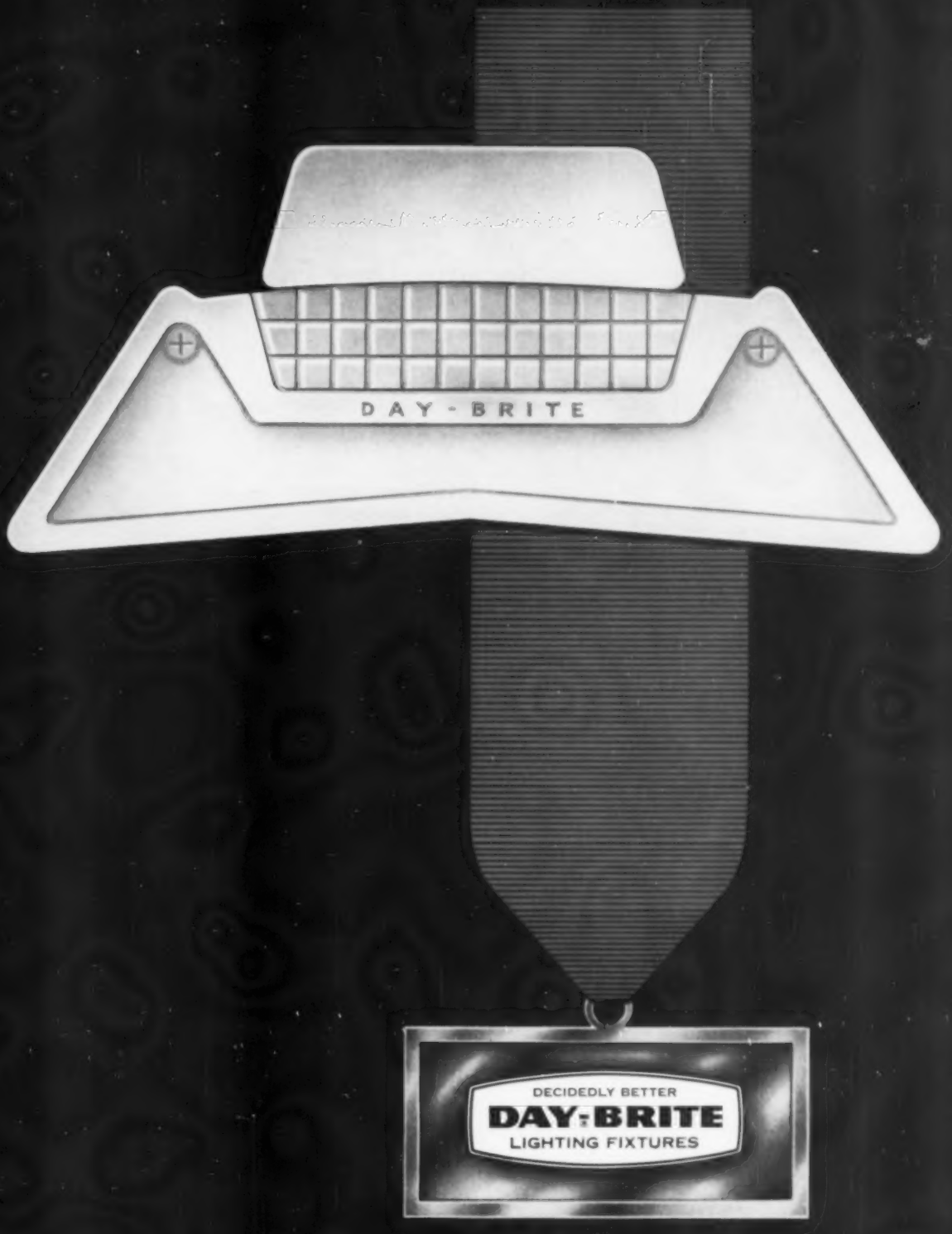
The shower stall, as used in one Georgia nursing home, is 85 inches long and 40 inches wide. It is built for multiple use—either for patients on stretchers or in wheel chairs, or for ambulatory patients who may be seated on a chair in the shower. The shower is equipped with safety grab rails and two shower heads in addition to the flexible rubber hose with a small spray head that can be used to bathe a patient on a stretcher. A plastic curtain hangs in front of the area to protect the attendant.

Attendants giving showers to patients on stretchers should wear rubber aprons, the department recommends, although there is little splashing from the rubber hose with its small spray head. It is not necessary for the attendant to stand behind the curtain when giving a shower or to walk around in the shower stall, as all parts of the patient's body can be reached easily. — Dr. R. C. Williams, *Director of Hospital Services, Georgia Department of Public Health.*

Shower can be used by a seated patient. Grab bars add to safety.



With flexible shower curtain, aide can stand outside partly drawn curtains.



FAIRVIEW

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Public Is Baffled by Hospitals Because They Fit No Pattern

By Gordon Davis

Gordon Davis

THE hospital image as it exists in the public mind today should be a fascinating subject for investigation by psychologists.

For the fact is, the institution that we call a hospital is neither fish nor fowl. It is not a charitable institution, but neither is it a business. It is nonprofit, but it absorbs large sums of money.

Management of the hospital's activities is a divided responsibility, split between administration and medical staff. Within the hospital, volunteers contributing their time work side by side with paid employes.

The hospital is as essential as a public utility, but it operates without comparable regulation. It is noncompetitive, but in Blue Cross it has an aggressive sales department.

Hospitals are operated by religious orders, by local, state and national governments, by labor unions, by industrial firms, by individuals, by community groups. They cooperate closely in some respects; they reject common action in others.

No two hospitals are exactly the same. It may justifiably cost twice as much to have an appendix removed in one hospital as in another in the same community. Hospitals are administered by doctors, nurses, the clergy, accountants, trained laymen, businessmen, pharmacists.

So tell me in a few well chosen words: What is a hospital? Is it related to a church? Should it be considered as a community facility something like a school? Is it essentially a business operation? Or is it basically a public utility?

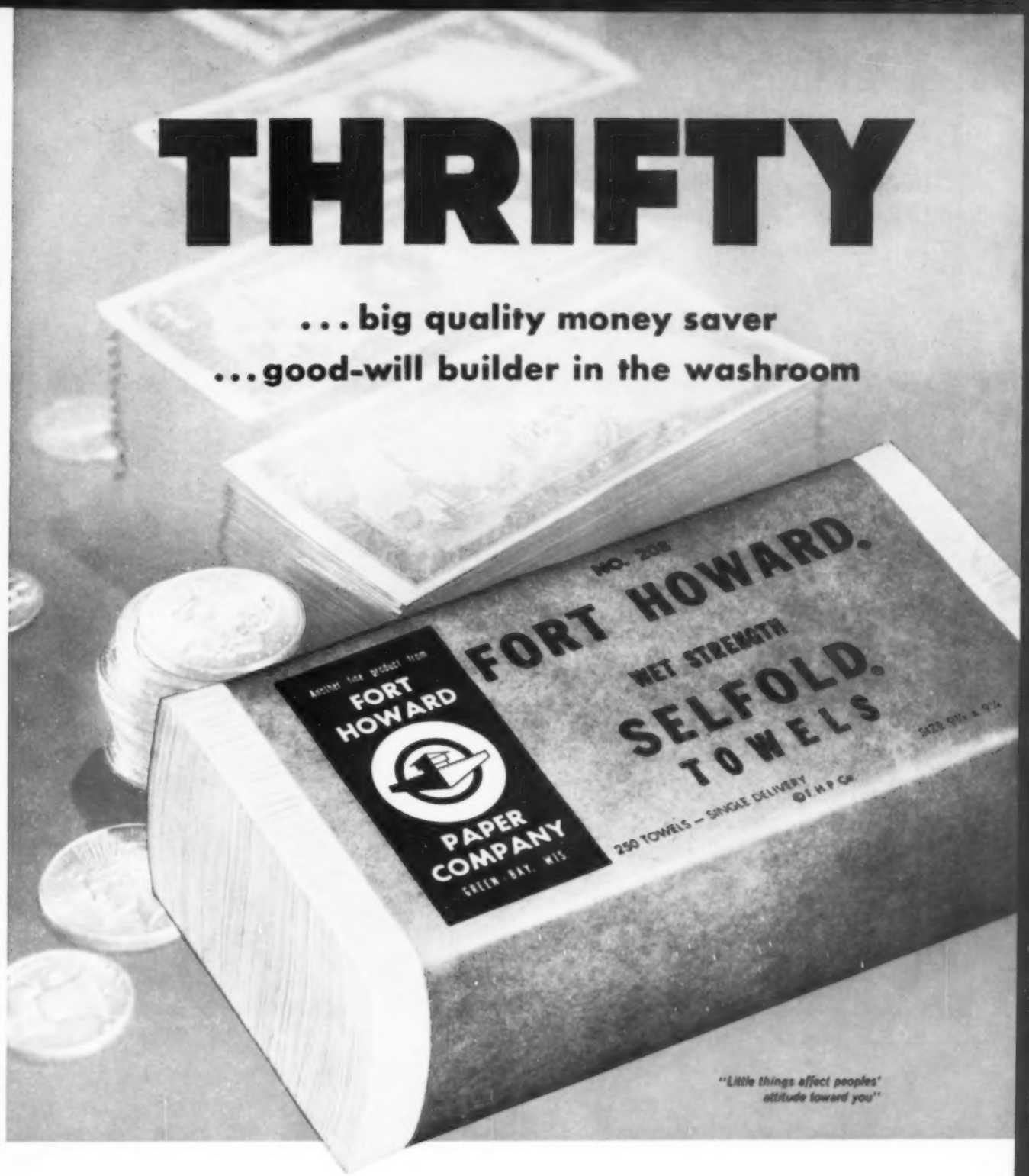
Because the hospital is an institution unto itself, borrowing motives and methods from many fields but characteristic of none but its own, it fits into no convenient standard patterns.

This is what makes judgment of hospital performance so difficult for the public. When the hospital was essentially a charitable institution, it slipped comfortably into a familiar niche which the people allowed it to occupy without mental reservations.

Not so today. Social, economic and scientific change have thrust the hospital out of its historic framework and made it a strange organism, motivated like a charity, operated like a business, regulated like a profession, governed like nothing else in our society.

How can we convince the people that this is good? How can we show that division of authority between trustees, administration and medical staff works to public advantage? How can we prove that the controls over hospital standards and hospital costs are effective controls, even though relatively free from competitive influences and legislative regulation?

Surely we can do these things only by bringing the hospital closer to the people — and the people closer to the hospital — through the application of enlightened public relations principles. It is fair to ask whether this purpose is fundamental in your own public relations program and, if so, exactly how it is being implemented with specific activities. ■



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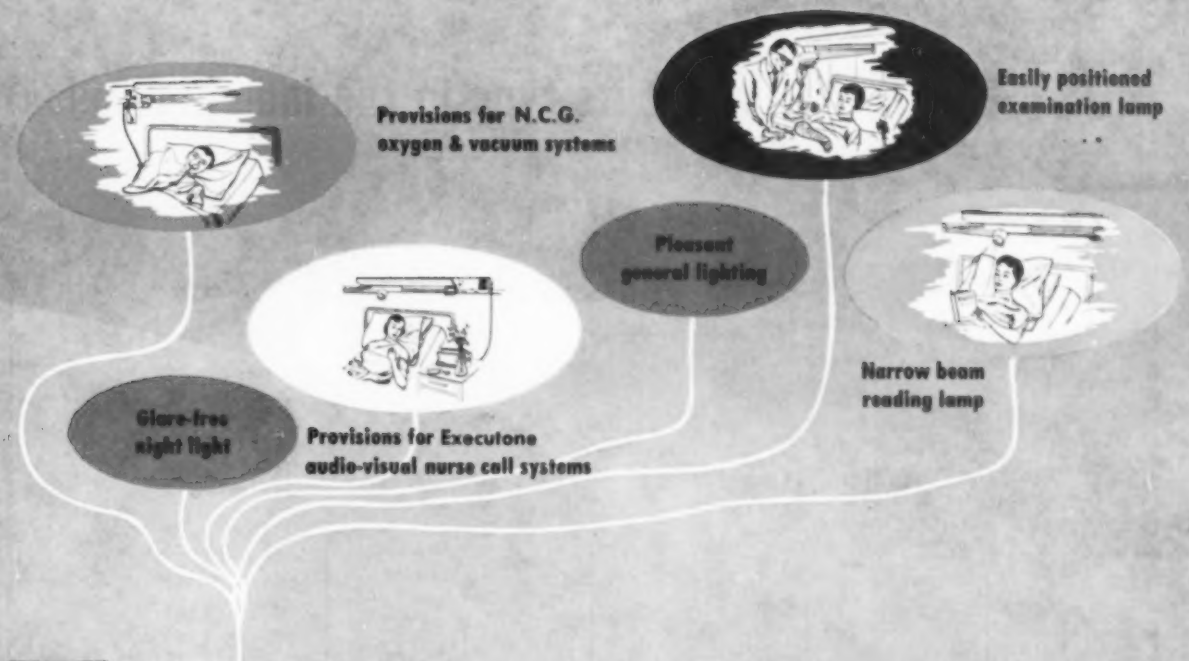

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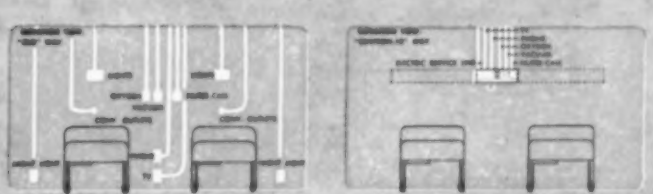

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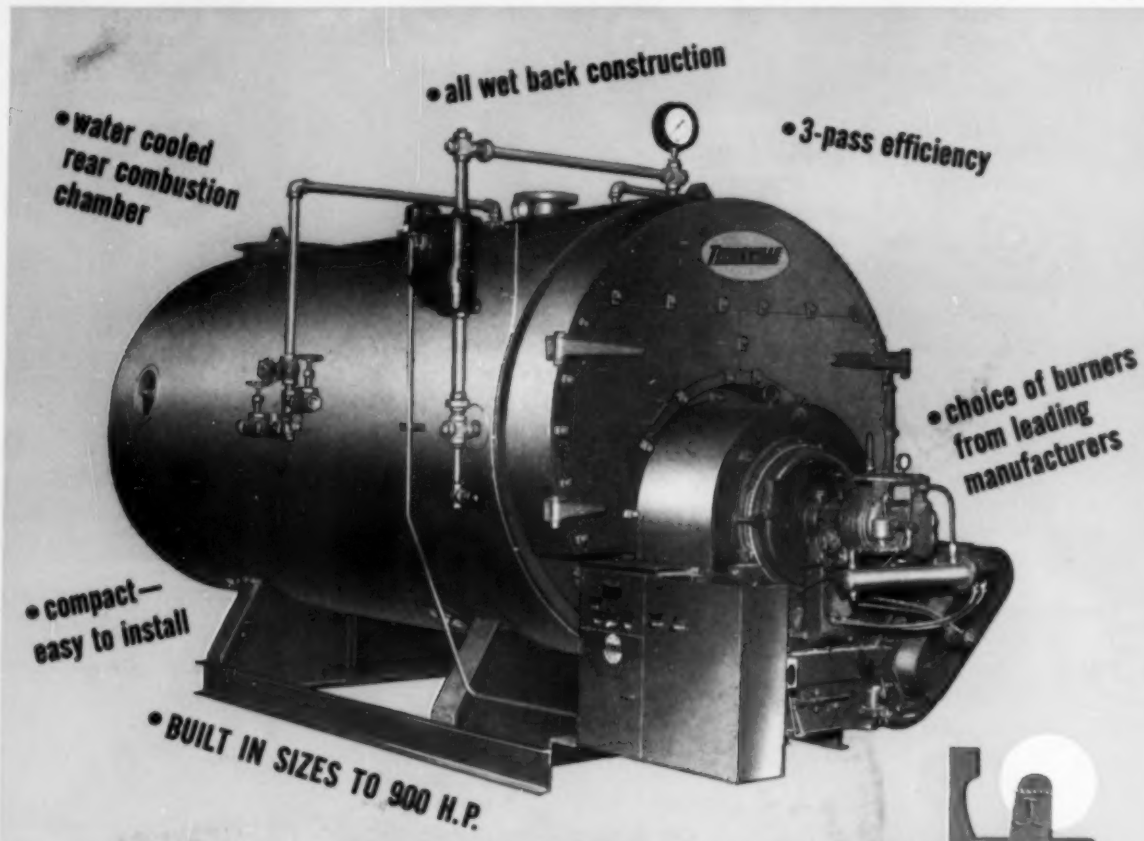

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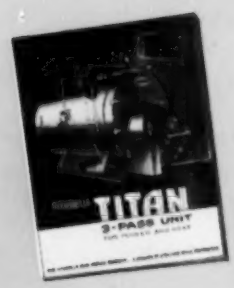

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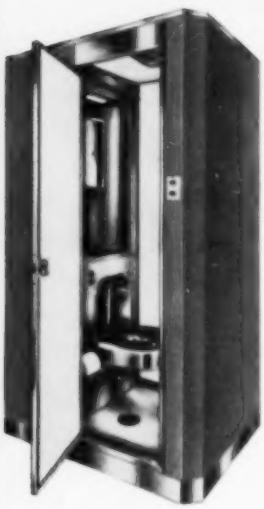

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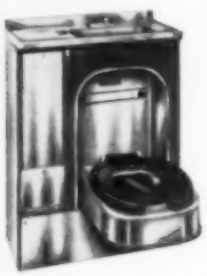

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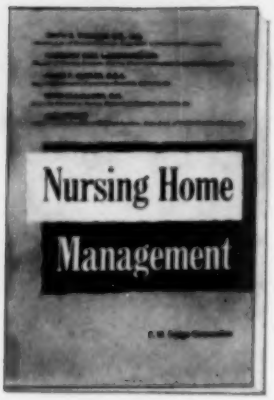

NURSING HOME MANAGEMENT

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Margaret Bull Armstrong, R.N.
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How can you insure 24-hour doctor's services?
How can your resident's life be made more enjoyable and meaningful?
Can low-sodium diets be made more palatable?
When is it more economical to have your own laundry facilities?
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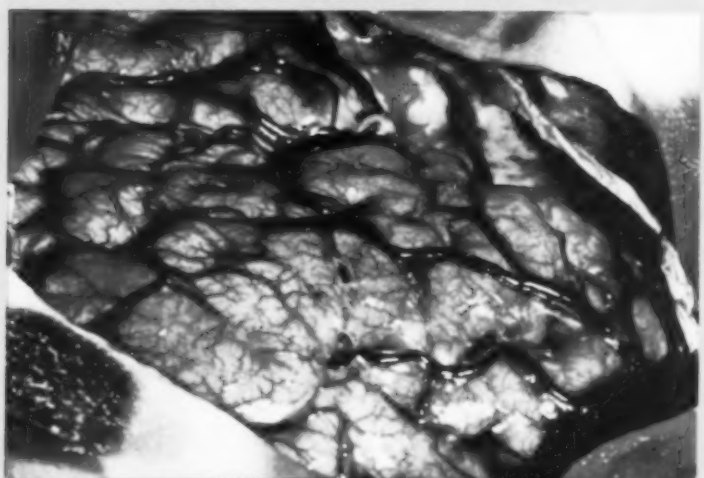

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*Javid, M.: Urea—New Use of an Old Agent, Reduction of Intracranial and Intraocular Pressure, S. Clin. North America *38*:907 (Aug.) 1958.

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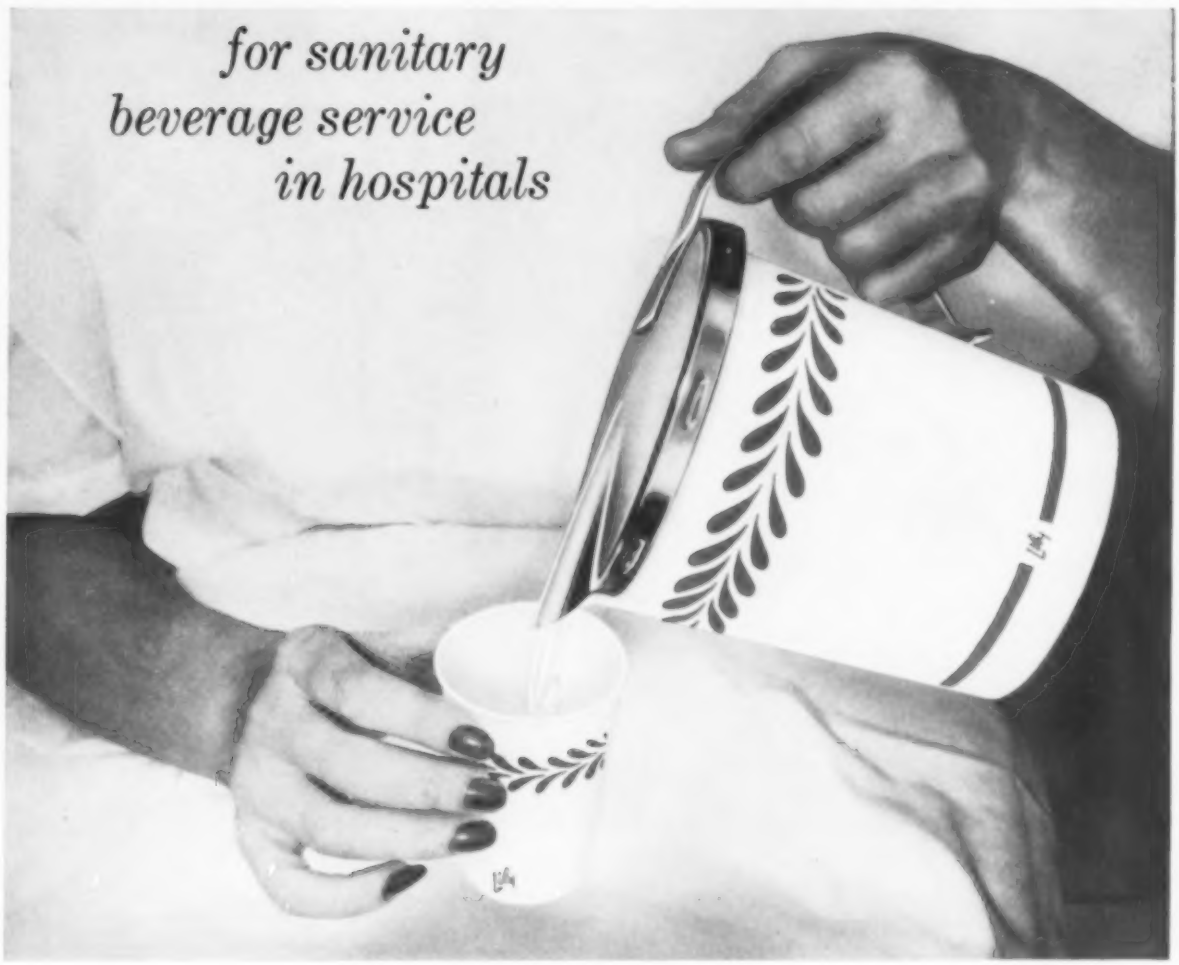

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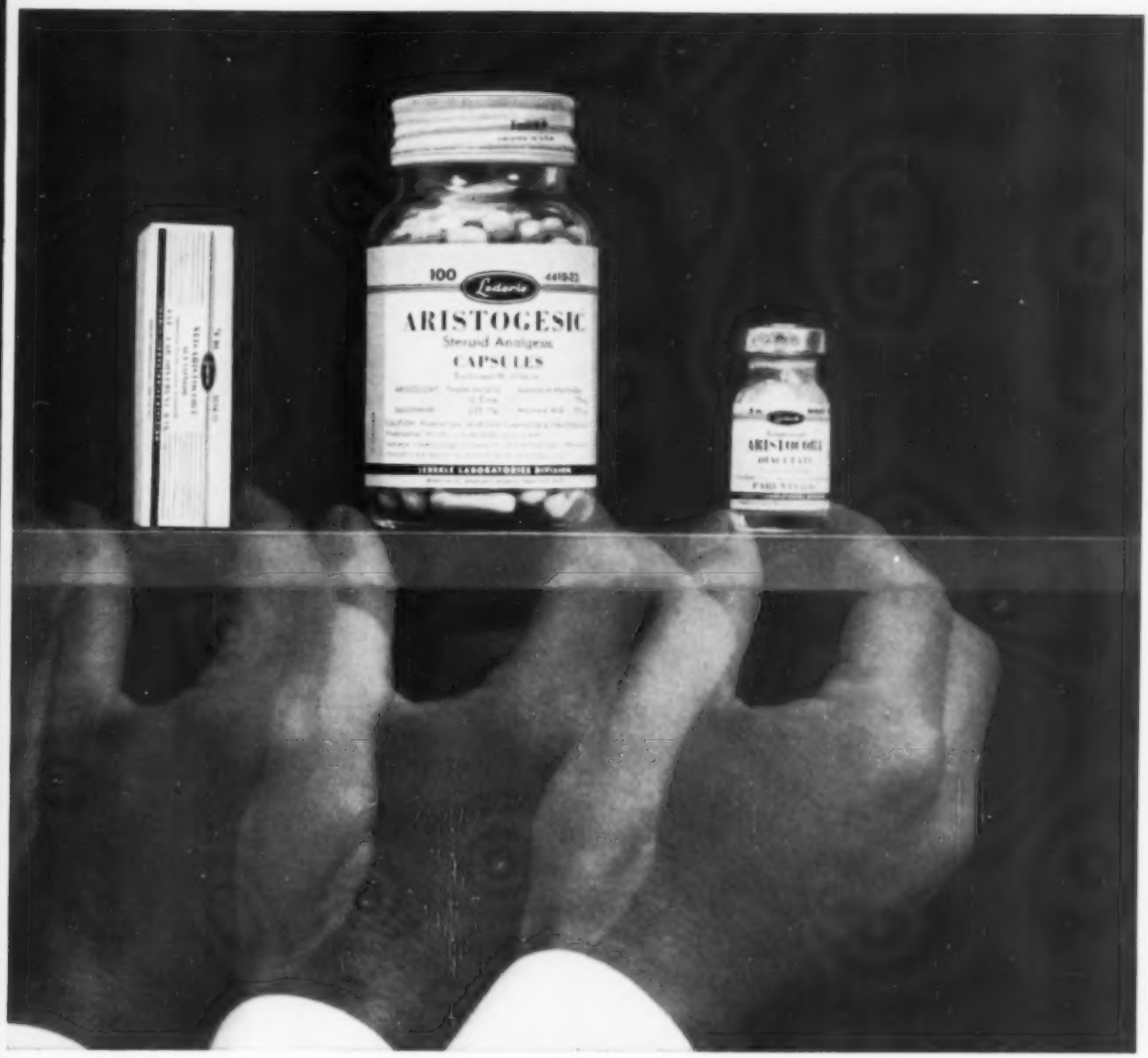

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How hospitals eliminate a dangerous source of bacteria– Airborne Dirt

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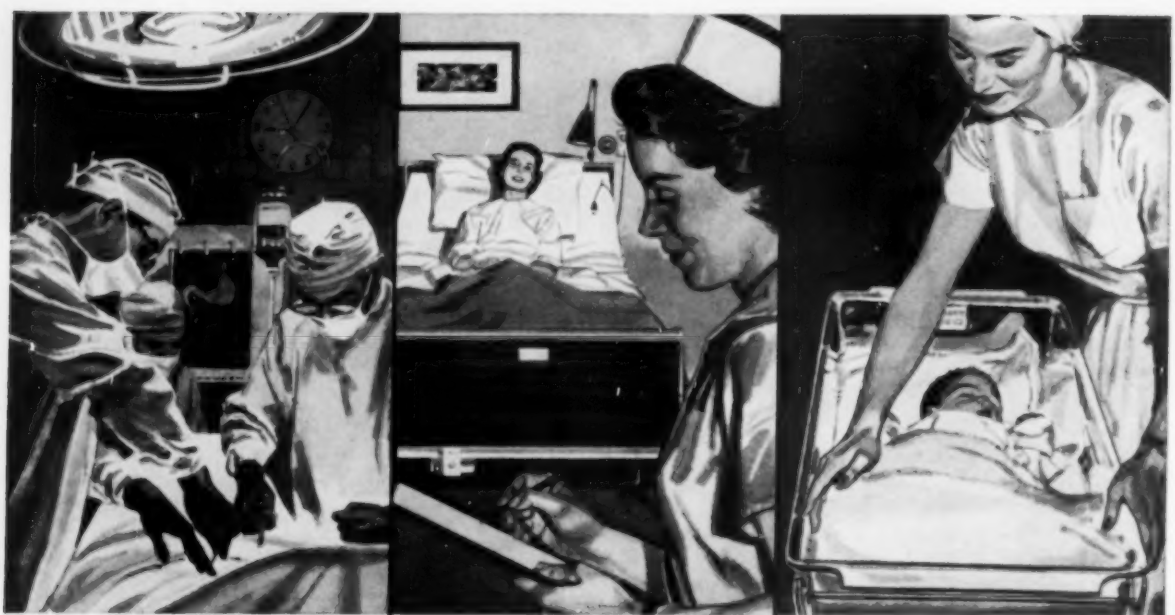

The accumulation of germ-laden dirt and dust in the ventilating and air conditioning ducts creates a hidden menace in the heart of the hospital. It is *vital* to keep these areas as free of dirt and dust as possible.

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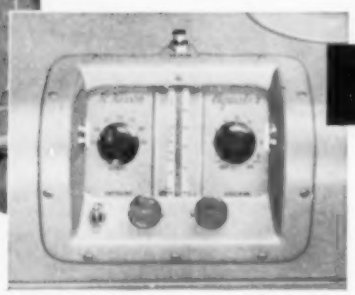

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note oxygen flowmeter (center), temperature and ventilation controls (left and right), oxygen controls (bottom).

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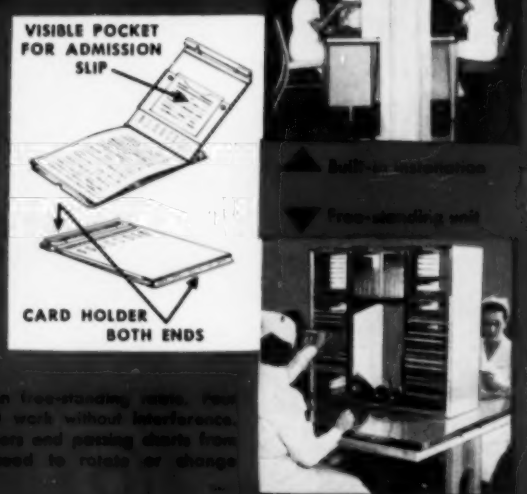

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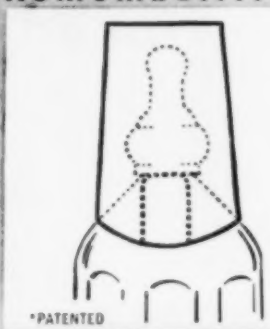

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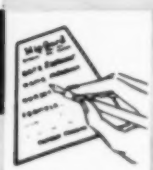

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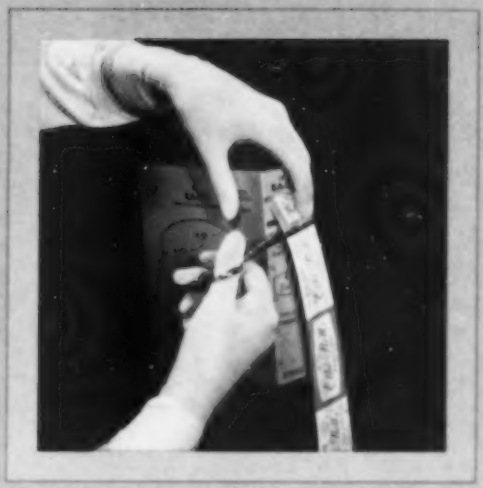

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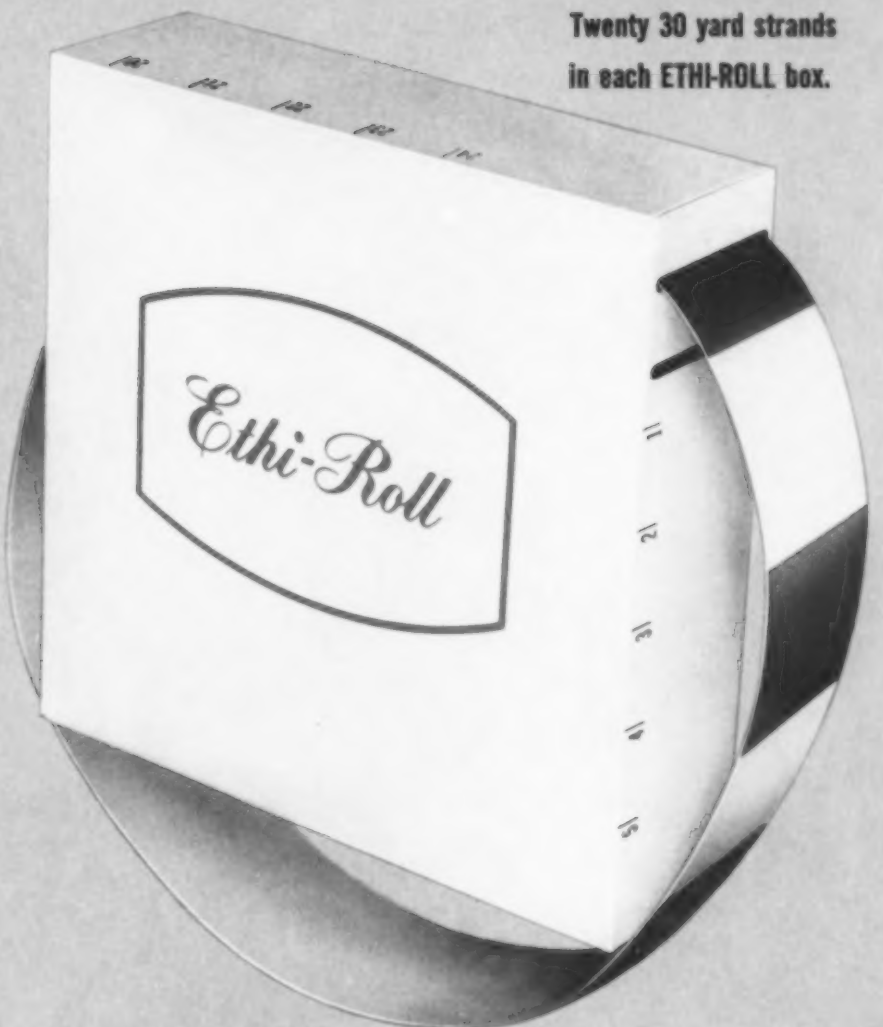

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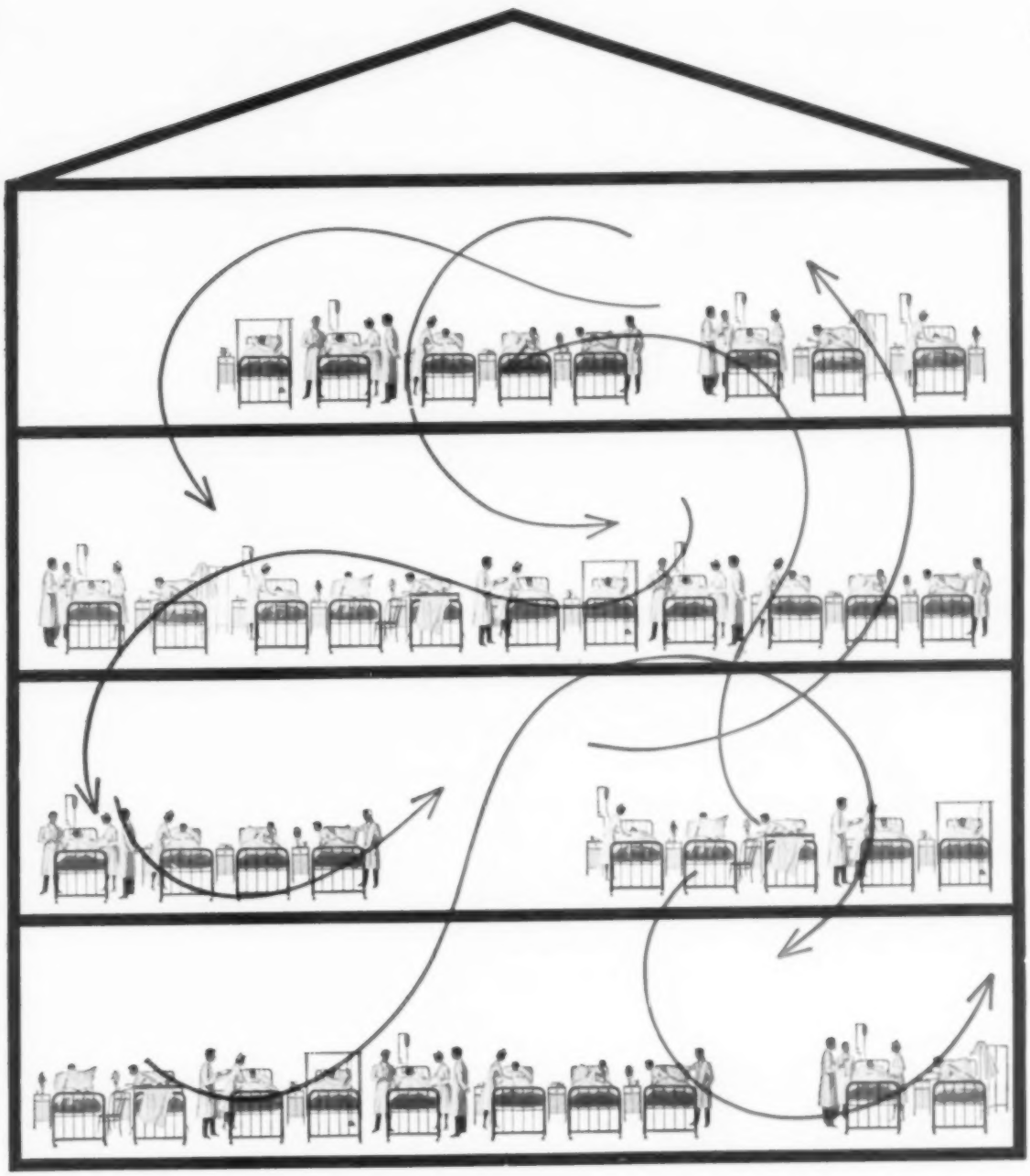

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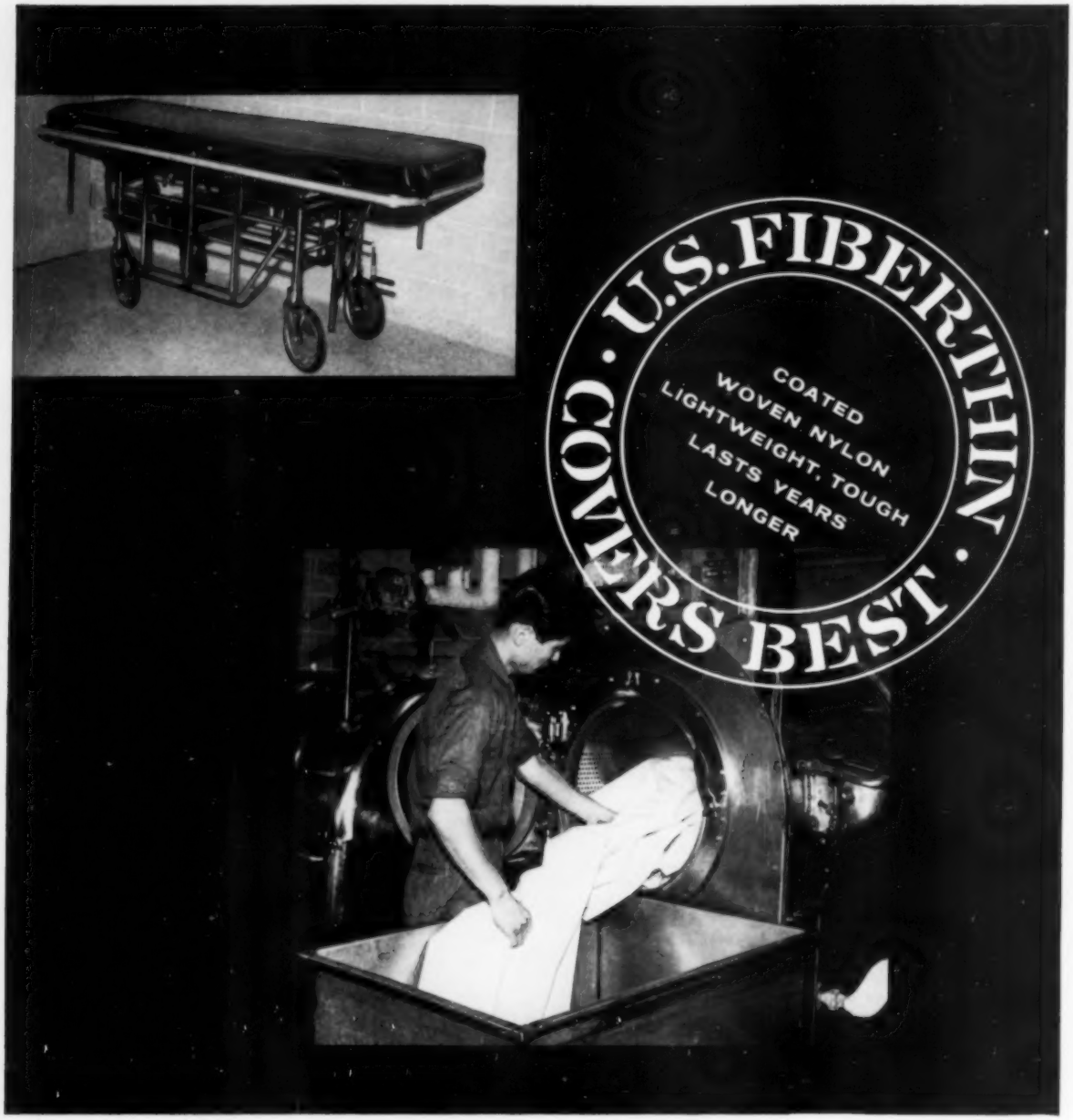

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says R. Kilgore, Director of Housekeeping and Laundry Service, Memorial Hospital, South Bend, Indiana

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Ask your supplier for U. S. Fiberthin—in rolls than can be cut to any size, or be made into fitted covers. For additional information, write United States Rubber, Mishawaka, Indiana.

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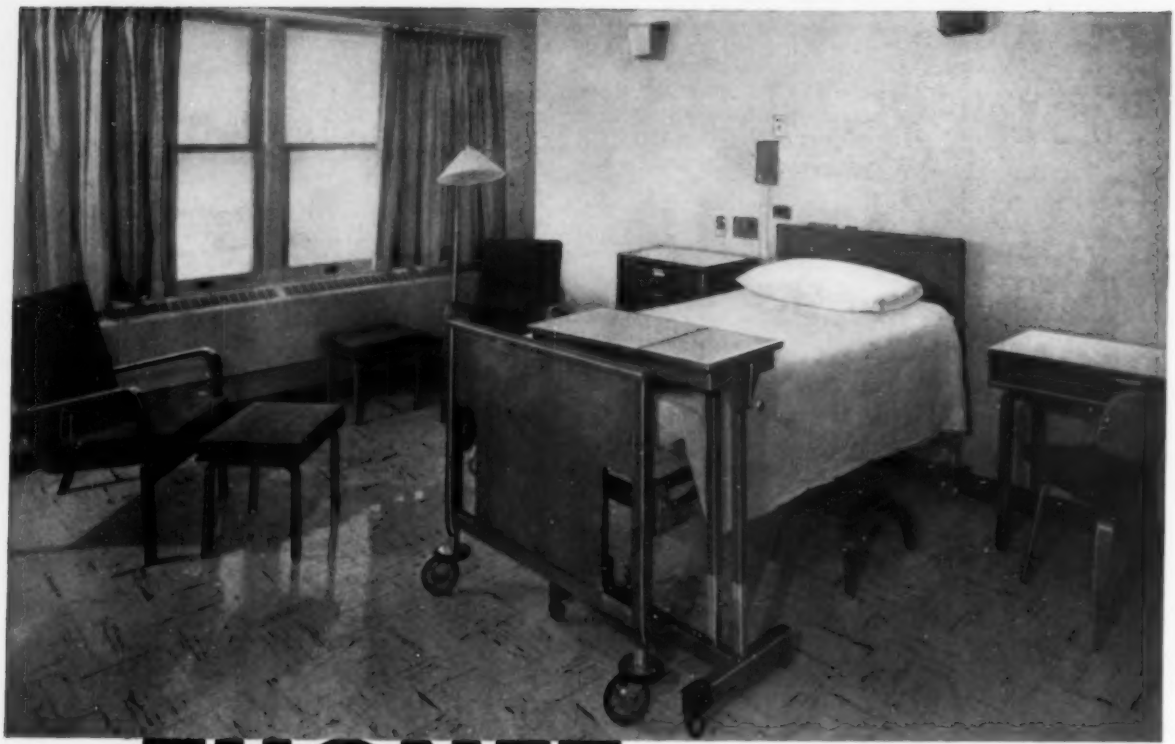

patients' room: furniture from group 800

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...*furniture for hospitals*

day room: 5320, 1295 chairs and tables

cafeteria: 1175 chairs, 3164 tables

lobby: 3252 settees, 3251 chairs and tables

The People's Hospital Authority of the State of Michigan* uses attractive, durable THONET furniture in patients' rooms, lobby, cafeteria, dayroom . . . throughout the hospital. Patients enjoy the home-like atmosphere of THONET wood furniture. Its functional, contemporary styling and structural strength are engineered for efficient hospital operation.

**Architects: Smith, Hinchmann & Grylls, Detroit*

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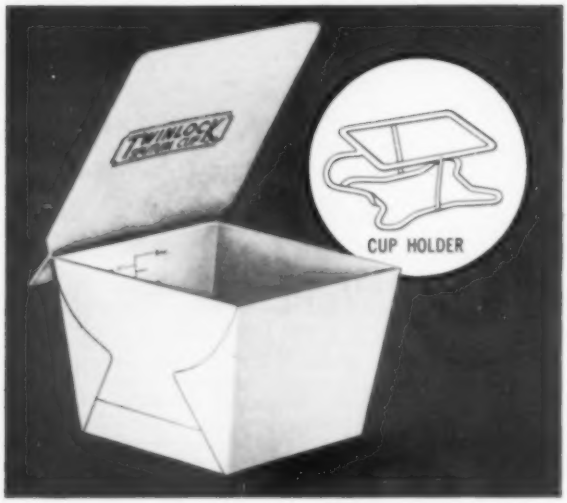

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Used in hospitals and sanitaria all over the world, the Burnitol "Twinlock"® sputum cup is the modern, inexpensive, and safe way of handling and disposing of sputum. The "Twinlock" is a one piece cup with an integral cover, which has a patented locking device to insure complete closure. It is generally used with the Burnitol Wrightlock® Holder, however, the "Twinlock" can be safely used alone if desired. Contents can be easily measured by marked graduations on cup interior.

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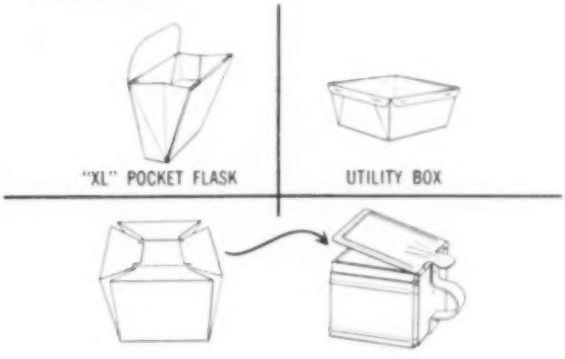

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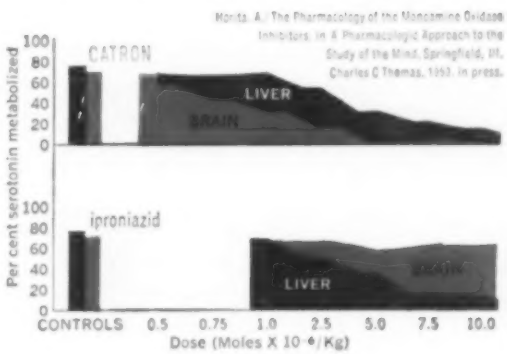
Elevates mood, brightens outlook by raising levels of mood-controlling neurohormones, serotonin and norepinephrine . . . at doses which have little or no effect on the liver.



Lakeside Laboratories, Inc. Milwaukee 1, Wisconsin

Radiant Ceiling News

With Burgess-Manning Ceilings — Your Building Is Better — Your Building Budget No Bigger

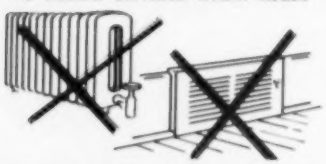
Radiant Acoustical Ceiling Ideal for Psychiatric Hospital

Quiet—Efficient Inaccessible— Safe for the Mentally Disturbed

The efficient, dependable and economical performance of the Burgess-Manning Radiant Acoustical Ceiling has been proved in numerous institutional and commercial buildings.

However, certain of the outstanding features of the Burgess-Manning Radiant Acoustical Ceiling make it particularly desirable as a means of comfort conditioning the psychiatric hospital. Were it designed for exclusive use in psychiatric hospitals, the Burgess-Manning Radiant Acoustical Ceiling could not be better suited for this type of institution.

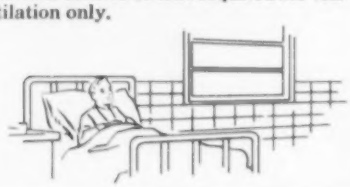
No Heated Surfaces Within Reach



There are no hot radiators or registers, that might harm a mentally irresponsible patient, within reach. All thermostatic controls can be located where only authorized supervisory personnel have access to them.

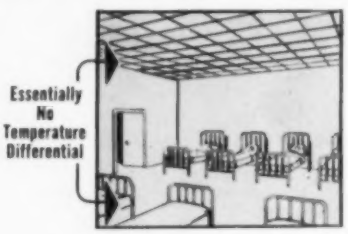
No Heated or Cold Air Currents

With the Burgess-Manning Radiant Acoustical Ceiling, comfort conditioning is accomplished by radiant energy, not by convection air currents. Consequently there are no hot or cold drafts with potentially deleterious effects on patients, particularly those who are mentally incapacitated. Any air movement is limited to that required for ventilation only.



Uniform Temperatures Throughout Room

With radiant ceiling heating, temperatures are uniform in all parts of the room. Even adjacent to windows, there are no cold or hot areas to aggravate patients, or to induce colds. Room temperatures are uniform from floor to ceiling as well.

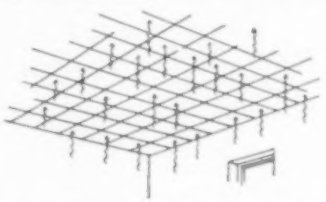


Floors Are Always Warm

With these mentally disturbed patients, and with children as well, it is important that floors are warm. This is one of the principal advantages of radiant ceiling heat. The radiant energy from the ceiling is converted into heat only when it is intercepted by a solid object, and the floor in almost every room receives the largest part of the radiant energy emitted from the ceiling. Therefore, the floors are always fully as warm as other parts of the room, rarely true with other older types of heating.

Cooling Equally Efficient

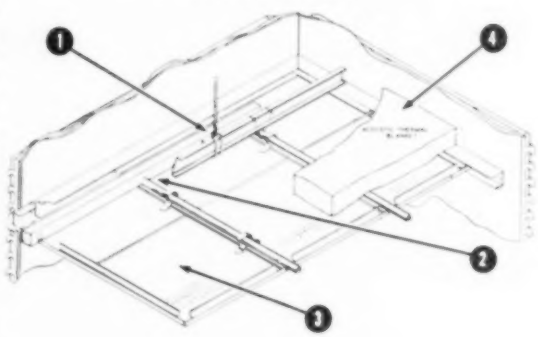
On the cooling cycle, the Burgess-Manning Ceiling operates in reverse. The



cool water circulated in the coils, absorbs radiant energy from the room and reduces the sensible heat of the room.

Basically Simple, But Amazingly Efficient

The deceptively simple construction of the Burgess-Manning Radiant Acoustical Ceiling is scarcely indicative of its operating efficiency. A standard 1½" channel grid (1) supports a grid or sinuous type galvanized coil (2). Perforated aluminum panels (3) are fastened directly to the coil (2) and a sound absorbent blanket (4) is laid on top of the suspension grid (1). Thermostatically controlled hot water circulates through the coil (2) and warms the aluminum panels (3) which transmit radiant energy to the floor, walls, furniture and occupants of the room and provides a high degree of comfort conditioning. On the cooling cycle, the process is reversed so that cool water, with temperature above the dew point to eliminate condensation, cools the panels. The cool panels absorb radiant energy (heat) from the objects, floor and walls of the room.



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3 Heating Cooling Acoustical

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withdrawn **apathetic** rejected **gloomy**
remorseful hopeless **listless** despairing
forlorn **somber** defeated
bitter crushed

WHEN THE WORDS MEAN DEPRESSION, THE TREATMENT IS

Catron®

β-phenylisopropyl hydrazine supplied as the hydrochloride

Important new psychoactive agent—acts selectively on the brain to brighten outlook, raise spirits, rebuild self-esteem, revitalize depressed patients.

Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin

For detailed information, request Brochure No. 15 CATRON 60990-D

Important New

Catron®

β-phenylisopropyl hydrazine supplied as the hydrochloride

Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin

How to use this new drug:

CATRON Hydrochloride is a monoamine oxidase (MAO) inhibitor useful in the treatment of depression and of other disorders indicated below. It is recommended for use in carefully selected cases and in those patients who have not responded to the milder drugs.

ADMINISTRATION AND DOSAGE

Dosage of CATRON must be individualized according to each patient's response. The initial daily dose should not exceed 12 mg. and should be reduced as soon as the desired clinical effect is obtained. In severe depressions some clinicians desire rapid results and begin treatment with 24 mg. daily: this dosage should not be continued for more than a few days. A single daily dose in the morning is recommended. A continuous or interrupted schedule may be used, the latter during the maintenance period.

DEPRESSION (Endogenous, Reactive, Postpartum, Involutional and Depression Secondary to Schizophrenic or Neurotic Reaction): initially, 12 mg. once daily for approximately 2 weeks, or less if improvement appears. Dosage is then reduced to 6 mg. daily. As improvement continues, maintenance dosage of 6 mg. every other day or of 3 mg. daily often proves satisfactory. An interrupted dose schedule is recommended for long-term therapy.

ANGINA PECTORIS—3 to 6 mg. daily in most cases. Relief of pain and elevation of mood may be dramatic. Victims of angina pectoris who respond in this manner should be cautioned against overexertion induced by their sense of well-being.

RHEUMATOID ARTHRITIS (Adjunctive Therapy—in severely disabling forms, particularly when accompanied by depression): 9 to 12 mg. daily for 3 days, then 6 mg. daily, reducing further to 3 mg. daily on signs of improvement. If a conventional antiarthritic agent is used, lower doses of each are indicated.

CAUTION

Certain circumstances should be watched carefully when using CATRON.

DRUG POTENTIATION—The list of drugs which CATRON potentiates is not yet complete. CATRON should not be used concomitantly with any other drug unless, (a) it has been ascertained that the two drugs bear no qualitative relationship, or (b) potentiating action is being sought, as may be the case with tranquilizing drugs including reserpine and the phenothiazines, and with the amphetamines, barbiturates and hypotensive agents.

HYPOTENSIVE EFFECT—All normotensive patients receiving CATRON, but especially elderly patients, should be warned about the possibility of orthostatic hypotension during the initial period of higher dosage. In the few instances where this may occur, lowering of the dose will usually permit continuation of therapy.

COLOR VISION—A reversible red-green color defect has been reported in a few patients, chiefly hypertensives, on ex-

Psychoactive Agent

- Brightens mood, diminishes apathy and confusion, curbs symptoms of withdrawal, self-pity, inadequacy, despair.[1,2]
- Acts selectively on brain at doses having little or no effect on liver.[3-7]
- Valuable in depressions associated with chronic diseases such as angina pectoris,[8] severe rheumatoid arthritis.[9]

For detailed information, request Brochure No. 19, CATRON

tended therapy with CATRON. Discontinue the drug if such changes occur.

ANIMALS, NEUROLOGIC SIGNS—In toxicity studies with animals, a neurologic syndrome has been observed characterized by tremors, muscle rigidity and difficulty in locomotion. Although extensive clinical experience has not shown such reactions to be a problem in humans in recommended dosage, should a similar neurologic disturbance occur, the possibility of drug action should be considered.

SIDE EFFECTS—Major side effects requiring cessation of therapy are infrequent. Other side effects—constipation, delay in starting micturition, increased sweating, hyperreflexia, ankle edema, blurring of vision, dryness of the mouth—are usually readily controlled by lowering the dosage. Rash, observed in a few patients, cleared up rapidly upon discontinuing therapy.

WARNING: Pharmacologic studies show that with proper dosage CATRON will inhibit monoamine oxidase in the brain without influencing this enzyme in the liver. This is in contrast to previous inhibitors, which depress monoamine oxidase activity in the liver before affecting this enzyme in the brain.

Although the evidence suggests that serious life-threatening hepatitis seen with other MAO inhibitors should not occur with CATRON in the recommended dosage, it has been reported on rare occasion with dosages in excess of the recommended levels.

The Following Precautions are Recommended:

1. In all instances daily dose should not exceed 12 mg.
2. Reduce daily dose as soon as response is established, usually in a matter of 1 to 2 weeks.
3. Do not prescribe to a patient more than sixteen 6 mg. tablets or thirty-two 3 mg. tablets of CATRON at one time.
4. Patient should return for observation before additional CATRON is prescribed. For this reason, prescriptions for CATRON should be marked, "not refillable."
5. Perform regular liver function tests.
6. Do not use the drug in patients with a history of viral hepatitis or other liver abnormalities.

CATRON is the original brand of β-phenylisopropyl hydrazine. It is supplied as the hydrochloride in tablets of 3 mg. and 6 mg., bottles of 50.

(1) Agin, H. V.: The Use of JB-516 (CATRON) in Psychiatry, Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958. (2) Bercel, N. A.: A Pharmacologic Approach to the Study of the Mind, Springfield, Ill., Charles C Thomas, 1959, in press. (3) Kinross-Wright, J.: Panel Discussion of Psychic Energizers, *ibid.* (4) Kinross-Wright, J.: Experience with JB-516 (CATRON) and Other Psychochemicals in Clinical Practice, Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958. (5) Horita, A., and Parker, R. G.: Comparison of Monoamine Oxidase Inhibitory Effects of Iproniazid and Its Phenyl Congener, Proc. Soc. Exper. Biol. & Med. **99**:617, 1958. (6) Horita, A.: *Beta*-Phenylisopropylhydrazine, A Monoamine Oxidase Inhibitor, Fed. Proc. 17:379, 1958. (7) Horita, A.: The Pharmacology of the Monoamine Oxidase Inhibitors, in A Pharmacologic Approach to the Study of the Mind, Springfield, Ill., Charles C Thomas, 1959, in press. (8) Kennamer, R., and Prinzmetal, M.: Treatment of Angina Pectoris with CATRON (JB-516), Am. J. Cardiol. 3:542, 1959. (9) Scherbel, A. L., and Harrison, J. W.: The Effects of Iproniazid and Some Other Amine Oxidase Inhibitors in Rheumatoid Arthritis, Conference on Amine Oxidase Inhibitors, New York Academy of Sciences, Nov. 20-22, 1958.

(advertisement)

How to Avoid "Drug Irritation"

A candid look at the unique Drug Management Problem In The Hospital and its solution

by Alfred A. Mannino
EXECUTIVE DIRECTOR, HOSPITAL DEPT.
McKESSON & ROBBINS, INC.

Did you know that each day since 1940, an average of one new drug item has appeared on the market? In 1958 alone, a total of 370 new products made their appearance; new dosage forms totaled 109; and over the last ten years, 894 product duplications have been marketed. Today, with the ever increasing number of new items, new sizes, and recurring duplication, "drug irritation"—the problem of drug inventory management—steadily mounts.

Buying and inventory procedures especially in a hospital, are as important to proper drug management as the skillful preparation and dispensation of the drugs themselves. When you consider the some 7000 items with which the average hospital annually deals, the problem of not knowing what to stock, how much to stock, and when to stock it, means the loss of time and money. Most hospitals, not having an extensive outpatient department, find it impractical to keep more than 1500 items in regular drug stock, and when an emergency arises, many times supplies are out of stock, or insufficient to meet the immediate demand. With continuing population growth, additional strain is placed on already overcrowded hospitals, and the volume of drugs hospitals use, increases proportionally.

How to cope with these unmatched complexities, is one of the toughest problems facing most hospital staffs today. And when you realize that less than half of the 7000 hospitals in the country have accredited pharmacists on their staffs, the problem seems staggering. Without a trained pharmacist, pharmacy purchases are made by the overworked doctor or nurse—or even by the administrator himself. With over 30% of every hospital supply dollar going for pharmacy purchases, the person in charge of your pharmacy faces unparalleled business and professional responsibilities.

What's the solution? Fortunately, there is a way to solve these pressing and complex problems. By specially tailoring drug inventory management to specific needs, your hospital can make time and money—by saving it.

With scientific inventory management you can literally extend your storage space and increase your hospital staff, by relying on a supplier uniquely equipped to service hospital pharmacies. A good supplier is able to give you competent professional advice on any specific problems you may have. He will select drugs and drug products produced by reputable manufacturers, insuring reliable merchandise. He will maintain a stock level tailor-made for your particular needs. This means the combined money and time costs of procuring (average—50 cents per item) and carrying supplies (average—10%) will be held to a minimum.

Many hospitals rely on McKesson's "Rex" McKay® for professional assistance and advice on the many problems peculiar to hospital drug management. In the person of "Rex" McKay *you* can add a highly trained man to *your* hospital staff. For "Rex" McKay is a professionally trained hospital pharmacy specialist, a drug therapy consultant ready to advise you on the unique problems a hospital faces in management of drugs. For instance on new drugs "Rex" McKay receives advance information from over 75 leading manufacturers (represented by 14,828 detail men!) at least fifteen days before release date on each new item. He adjusts his stocks accordingly and is ready to meet your demand when it occurs. He is equipped to quickly supply you with emergency service as well as day to day delivery and to keep you posted on the latest drug developments. (He receives up to a hundred telephone inquiries every day.) "Rex" McKay allies himself closely with your staff, and together with the McKesson salesman you develop an inventory management program, tailor-made for your hospital's individual pharmaceutical requirements.

With 82 Hospital Service Departments located strategically throughout the country, "Rex" McKay is readily available to serve you. McKesson's Hospital Service Departments also provide warehouse facilities, so you actually extend your own storage space. In every way, McKesson & Robbins "Rex" McKay works to keep your procuring and carrying charges at a minimum, solving the unique problems of drug inventory management in hospitals.

Let us send you the name of the McKesson Hospital Service Department nearest you—address inquiry to A. A. Mannino, McKesson & Robbins, 155 East 44th St., New York 17, N. Y.

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Since Red Seal is used in hospitals and clinics throughout the free world, its packaging is specially designed to withstand extreme ranges in temperature and humidity. Each 75-sheet box contains three 25-sheet packets, separately wrapped in heavy foil as added protection against moisture and accidental fogging.

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Ilford Red Seal is promptly available in the standard 5" x 7", 6½" x 8½", 7" x 17", 8" x 10", 10" x 12", 11" x 14" and 14" x 17" sizes from General Electric, Keleket, Picker, Westinghouse and their authorized dealers.

If your hospital has not yet tested this superior X-ray film and would like to do so, please contact any of the above-named suppliers for a no-cost demonstration.

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for maximum economy—Specify ACE hospital packaging. Individually polyethylene wrapped bandages, 2", 2½", 3" or 4" widths, in boxes of twelve...6" width in boxes of six. Readily available from your nearby distributor—the single source for most of your hospital supplies.

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SMALL HOSPITAL QUESTIONS

Who Hires Anesthetist?

Question: A minority group (three) of our surgeons recently lost by death a fellow physician who gave their anesthetics. Differences arising through the years between this minority group and the other members of the medical staff (nine members) apparently prohibits them from asking the medical men who give anesthetics for the rest of the staff to serve the minority also. They are therefore pressing the hospital administration to hire an anesthetist for their cases. Is it the hospital's responsibility to furnish an anesthetist for these surgeons?

Would it be wise to establish a precedent by acceding to such a request or demand from a small group within the medical staff? We feel that hiring an anesthetist would be proper only if her services were requested, and would be available, to the entire staff. The number of anesthetics an employe of the hospital would give for the three surgeons alone would be insufficient to keep the anesthetist occupied, or to pay the anesthetist's salary, it appears to us. What is your opinion? – R.R.H., Kan.

ANSWER: This inquiry was referred to a medical consultant who has replied:

It is the responsibility of the administration of the hospital to provide facilities for administration of anesthesia, to see that these facilities are safe, to determine that there are an adequate number of people to give anesthesia and, most important of all, to make sure that these people are qualified to do so. If your hospital meets these criteria, you have no obligation to provide an additional anesthetist to give anesthesia exclusively for a small group within the staff.

Information on Infections

Question: We are currently updating our programs for eliminating cross infections in the hospital. Could you recommend a source for background literature on this subject? – F. E. R., Wis.

ANSWER: The MODERN HOSPITAL published a number of articles on this subject in 1958 (January, March through September, November and December). In addition to these articles, the following material is available at no charge from the Public Inquiries Branch, Public Health Service, Washington 25, D.C.: "Recommendations of the National Conference on Hospital-Acquired Staphylococcal Disease"; "Recommended Procedures for Laboratory Investigation" from the same conference, and the publication entitled "Selected Material on Staphylococcal Disease."

To Avoid Design Faults

Question: We are looking ahead to a time when a new hospital building will have to be provided for our community, and are interested in conducting studies now aimed at making certain our new facility will function effectively in every possible way. What are the common problems or faults in hospital design we should pay particular attention to in these studies? – J.S., Ohio.

ANSWER: This question was referred to John N. Hatfield, director of Passavant Memorial Hospital, Chicago, who replied as follows:

"Certainly many aspects of hospital planning, with particular reference to layout giving effect to planning in such a manner as to make possible expansion of the basic facilities without unduly upsetting routine operation, need formal study. Too many hospital facilities are being planned without due regard to:

1. The relationship of the several functional elements of the hospital, one to the other.

2. The concentration and location of basic service elements in such a manner as to permit their expansion without interfering with the care of patients.

3. Acquisition of sufficient land to permit lateral development of the hospital plant, at the same time providing peripheral space for landscaping after provision is made for adequate car parking.

4. Hospital function taking precedence over esthetics.

5. Compactness in the interest of shortening distances of travel.

6. Inclusion of the latest labor saving devices.

7. Specifying interior finishes requiring a minimum of maintenance without emphasizing an institutional atmosphere.

8. Location of car parking facilities away from the front of the hospital.

9. Location of elevators away from patient accommodations.

10. Location of nurses' stations and floor clerk stations in such a manner as to properly supervise and control visitors.

11. Food service to patients.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Poison Control Information

Question: Where can our hospital obtain information that will help us develop an effective poison control unit within the hospital? – L.K., N.M.

ANSWER: Information on organizing a poison control and treatment center can be obtained by writing the National Clearinghouse for Poison Control Centers, Public Health Service, Washington, D.C. Dr. Howard M. Cann is director of the clearinghouse. The American Medical Association also has available recommendations on first-aid measures for poisoning adopted by the A.M.A.'s committee on toxicology.

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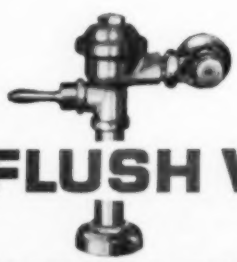
Save Water with Sloan Flush Valves

• Water is scarce in many parts of the country and it costs money. And costs often rise when it must be pumped (within a building) to distant branches and upper floors. You can save both water and money when you specify Sloan—the non-hold-open flush valve.

• The non-hold-open feature is a product of Sloan research. Its purpose is to prevent the waste of water—either accidentally or maliciously. A Sloan Flush Valve will complete its cycle and shut off automatically whether the handle is held or released.

• Non-hold-open is a standard Sloan feature—another bonus of quality you expect from Sloan. And since Sloan quality costs no more—why not make sure you get it.



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wire from Washington

FEDERAL EMPLOYES INSURANCE

Legislation for a U.S. employe health insurance program is moving ahead at a fine clip in the Senate—but problems are developing in the House.

For years this bill was held up because the people who would have to live with it—insurance interests, hospitals and labor—couldn't agree on the provisions. Now they are seeing pretty much eye-to-eye, but still the program faces another delay, possibly until next year.

Here is the situation:

After extensive hearings on the Senate side, the subcommittee staff worked up a bill that in general has the support of Blue Cross, Blue Shield, and the commercial insurance companies. The Eisenhower Administration, however, is not happy about it. The fact that the full committee promptly approved the bill and sent it on to almost certain passage in the Senate hasn't changed the White House sentiment.

On the House side, Chairman Tom Murray of the post office and civil service committee is sitting tight. For one thing, he doesn't want to schedule hearings until the measure comes over from the Senate, although his committee has before it an identical House bill on which it could start work.

For another thing, Mr. Murray points out that he said earlier he would not call hearings until *all* parties involved are in agreement—and this means the White House as well as labor and the insurance interests.

The new Senate bill, sponsored by Sen. Olin Johnston (D.-S.C.) and Sen. Richard Neuberger (D.-Ore.), has compromised most of the issues that blocked earlier bills. On the problems it didn't solve, the bill passed the buck to the Civil Service Commission, which would operate the program. This maneuver seems to satisfy everyone.

The White House has several objections. The main one is the estimated cost of just over $300 million. The Administration has said it doesn't want to add more than $250 million to the budget for the insurance plan. One of the real difficulties is that if the cost is held to much under $300 million, the Blues can't operate under the program, and it would all go to the commercial companies by default. So if Chairman Murray decides to shave off the authorized limit to make the White House happy, he will precipitate a bitter fight with the Blues. That's all that would be needed to put the bill back on the shelf.

One proposal, favored by Mr. Murray, is to hold up House action until next year, hoping that in the meantime some compromise can be found that both the Blues and the Administration can accept.

In introducing the bill, Senator Johnston declared:

"I believe the bill resolves most if not all of the differences of opinion and approach which have delayed congressional consideration of this important legislation in the past. The bill provides for a reasonable degree of employe choice among different kinds of health benefit plans. It permits choice without creating an administrative burden on payroll offices.

"It provides for a program of health insurance benefits which would automatically class the federal government as an enlightened employer, interested in the health and well-being of its employes and their families. The testimony during the hearings made it plain that up to now the federal government has lagged far behind private industry in this respect."

The employe would have a choice of two or three plans:

1. **Blue Cross-Blue Shield** and supplemental benefits package with basic benefits on a service basis, a deductible requirement and fixed ceiling on the amounts of co-insurance paid by the employe.

2. **An insurance company package** similar to above, but providing cash indemnity **benefits.**

3. **An insurance company policy** providing for a deductible requirement and co-insurance and applying to a wide range of **services.**

Later, the Civil Service Commission and the carriers would determine whether No. 2 or No. 3 would be offered, or both. At least there would be two choices.

The government and the employe would share the costs of the above about equally, but the government would pay the full costs of major medical coverage to be provided to all those under the basic program.

To hold down the costs of the entire operation, the bill rules out benefits for those presently retired, but would blanket those who retire in the future. Senator Johnston explained that the presently retired equal about 15 per cent of those now on the payrolls. Because their medical problems are more numerous and severe, they would add about 30 per cent to the total cost.

But the presently retired have not been forgotten. Senator Johnston said a study would be made of their medical cost problems. Senator Neuberger was more specific:

"For those of you who are concerned with the health needs of annuitants, let me say I hope to suggest a program particularly for them before long, within the next several weeks. One would be callous, indeed, to overlook the health needs of retired career government employes. As chairman of the insurance subcommittee I will do everything within my power to make certain that coverage is provided for them."

CONFERENCE ON AGED

The Washington conference of the Joint Council To Improve the Health Care of the Aged did more than stimulate interest in older people and their problems in financing medical care. It also served to accentuate a split within the council itself.

The council is made up of the American Medical Asso-

ciation, the American Dental Association, the American Association of Nursing Homes, and the American Hospital Association. The first three are adamant about the Forand bill for hospitalization of the aged under social security: They are convinced that it's a dangerous, unnecessary experiment and that it would point the way directly to a broad federal health program for the entire population.

But the American Hospital Association has a different idea. The A.H.A. is not endorsing the Forand bill, but its official policy is that the social security approach might eventually have to be used to solve the medical cost problems of the aged. Despite this position, A.H.A. continues to cooperate with the council.

One of the invited speakers at the conference was the popular (and liberal) Gov. Robert J. Meyner of New Jersey. The governor might have gotten his signals crossed, because in his talk he indicated that some program like the Forand plan might be a good idea.

The Joint Council, taken by surprise, had to react fast. It hurriedly prepared a press release, a proper and natural procedure, pointing out that the governor's views weren't the council's. One part of the release stated that the council's *four* sponsors were unalterably opposed to the Forand bill.

Many hospital people are not taking lightly this slip-up of the council's publicity staff.

A highlight of the conference was a report by Dr. Edward L. Bortz of Philadelphia, a former A.M.A. president, who said retirement should come at 90 years, not the conventional 65. He advised people to shift careers at 60, entering a new field and staying in it until 90. "When a man retires out of life, life retires out of him," he said. "To have a healthy body you must use it; if not you'll lose it."

Meanwhile, Rep. Aime J. Forand (D.-R.I.) continues his frantic efforts to induce Ways and Means Chairman Oren Harris to schedule hearings on the social security hospitalization bill. So far Harris has stood firm, but pressure from other liberal Democrats on the committee might force him to hold sessions for one or two days around the middle of July.

UNEMPLOYMENT COMPENSATION

Thanks to efforts of American Hospital Association, nonprofit hospitals were exempted from a bill that would extend unemployment compensation coverage. It is estimated that if the change had not been made hospitals would be faced with a new bill of at least $40 million the first year the law was in effect.

Hospitals' argument was that their employment record is one of the best in the country, and that participation in an unemployment compensation program would mean that they were in effect subsidizing industries with fluctuating employment patterns.

N.Y. Strike Ends; Terms Include Worker Representation But Not Union Recognition

NEW YORK. — The 46 day strike against seven voluntary hospitals ended here June 22 when Local 1199, Retail Drug Employes Union, agreed to a hospital policy statement embodying proposals for employe representation and arbitration of grievances.

Later in the same week, a strike for union recognition at Brooklyn Hospital, another voluntary institution, was called by Local 302 of the American Federation of State, County and Municipal Employes. In the same busy week, 37 New York proprietary hospitals agreed to a three-year contract covering 3500 nonprofessional employes with a third union, Local 144 of the Hotel and Allied Services Employes.

The policy declaration that settled the strike against the seven voluntary hospitals was adopted by the Greater New York Hospital Association and submitted to the association's 81 member hospitals for ratification.

The agreement did not provide for union recognition — the principal demand at issue in the strike — but Leon J. Davis, union president, described the hospital policy statement as a "partial victory" for the union because the proposed grievance machinery would permit representation of a worker by a union official.

Major provisions of the strike-ending agreement were:

1. A minimum wage of $1 an hour for a 40 hour work week, with time and one-half for overtime.

2. Establishment of a "permanent administrative committee" including six hospital trustees named by the Greater New York Hospital Association and six public representatives not associated with hospitals or labor to supervise implementation of the wage and hour program and conduct an annual review of wage levels, job grades, rate ranges, fringe benefits, seniority rules, and personnel policies.

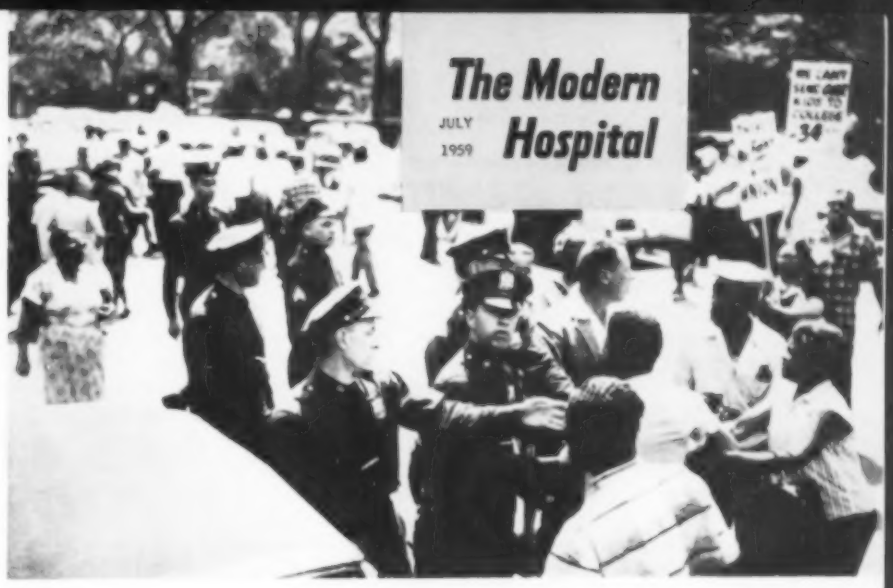
3. Establishment of a clearly stated grievance procedure in each hospital, with provision for mediation and arbitration outside the hospital in case of unresolved disputes. "In such mediation and arbitration the aggrieved employe may be represented by any one he may designate," the agreement stated. "Dismissals based upon lack of professional competence or incompetence, including all matters involving relations with or conduct of an employe toward patients, shall not be subject to the grievance procedure nor to arbitration except when the employe claims that the dismissal has been made for reasons other than professional competence or incompetence, in which case that issue, as distinguished from the question of professional competence or incompetence, may be submitted to the grievance procedure, with the burden of proof upon the employe."

4. No discrimination against any employe because he joins or remains a member of any union, or because he has presented a grievance under the proposed grievance procedure.

5. Dismissal of all legal action against the union, except an appeal from a state supreme court decision holding the hospital strike was a "bona fide labor dispute" and refusing to punish union leaders for contempt of a no-strike injunction. (Both sides agreed that an important matter of law was involved in the state supreme court decision and that the hospital appeal should be continued, but with the understanding that no punishment would be requested by the hospitals.)

6. Reinstatement of striking employes to former or comparable jobs without discrimination "as quickly as practical and feasible," with the exception of strikers found guilty of violence.

The Modern Hospital
JULY 1959



Policemen keep order as pickets stage a demonstration outside New York's Flower and Fifth Avenue Hospitals during strike for union recognition.

Nation's hospitals face union drive

CHICAGO. — Last month, it was plain to most hospital people that the thing they had dreaded for 10 years was actually happening: Unions had mounted a national drive to organize hospital workers. Unquestionably, the strike against voluntary hospitals in New York City was the noisiest and most critical labor dispute in hospital history, but it was only one episode among many. A hospital strike in Tulsa, Okla., had started earlier and was still dragging on last month; a 13 day walkout against five Oakland, Calif., hospitals ended when striking medical technicians received a $45 monthly increase; reports from a dozen other cities indicated unions were actively soliciting membership among hospital workers or, at least, planning to organize hospital drives. One union (Building Service Employes International Union, A.F.L.-C.I.O.) announced it was launching a campaign to organize 40,000 hospital maintenance workers, janitors, elevator operators, and window washers. At a meeting of hospital officials, 30 of the 36 states represented reported that union activity among hospital workers had increased noticeably since January 1 of this year; a survey made by one state hospital association revealed that of the 158 responding hospitals 15 were already unionized, 22 had been approached by unions and employes of 123 had been approached by unions.

Surprisingly, now that labor had dropped the other shoe, hospital people generally seemed more relieved than frightened, and resistance to union organization was stiffening, instead of weakening, last month. After six weeks, the strike-bound hospitals in New York had demonstrated that service could be maintained at acceptable levels inside picket lines. In Tulsa (where the hospital and union had come to terms but the strike was called anyway by a union official who claimed the hospital administrator's refusal to sign a contract without reading it was evidence of "mistrust"), striking maintenance workers had been replaced, and hospital operation was going forward as usual. Strikes and agitation had certainly made hospitals aware that substandard wages would have to be raised and personnel practices improved in many cases, but, while there were some who disagreed, most hospitals were more certain than ever that the hospital is no place for a union contract. With few exceptions, the most they were prepared to concede was the kind of community arbitration provided in Toledo (see page 76) and Seattle, where the Swedish Hospital resisted a demand for union recognition through a bitter 12 week strike last year (see page 63). When it finally came after 46 days, settlement of the New York strike provided for employe representation and arbitration of grievances, but not union recognition (see opposite page).

Why, after successful drives to organize hospital workers in Minneapolis 8 years ago, and in the San Francisco area some years earlier, had unions laid off hospitals so long, and what touched off the new drive in 1959? Many observers believed the nation's top union leaders had become alarmed because membership in the huge industrial unions has been declining in recent years, with a resulting loss in union revenues. "The hospital working force is a rich, new source of dues-paying union members, if it can be developed," an industrialist told a group of hospital administrators at one of the 1959 hospital conventions. Unquestionably, most hospital trustees and administrators agreed that it was the dollar, and not the downtrodden worker, that had attracted union attention.

Actually, the unions had never lost interest in hospitals; the 1959 membership drive was a resurgence rather than a new phenomenon. One hospital in Philadelphia, for example, was organized 10 years ago; a hospital strike in Portland, Ore., (where some hospital workers have belonged to unions for nearly 20 years) lasted almost 12 months in 1952, and the union there (Building Service Employes) recruits members constantly but has trouble keeping them in line; a hospital in Milwaukee (Mt. Sinai) has been unionized for years, but drives to organize other Milwaukee hospitals have met only indifferent success; local unions affiliated with the American Federation of State, County and Municipal Employes have enrolled workers in city hospitals throughout

the East; an operating engineers union has had contracts with three hospitals in Kansas City for 20 years. Elsewhere, teamsters, department store workers, drug employes and other unions have made repeated attempts to organize hospitals over the years. The 1959 effort was more widespread, and more widely publicized, but it was nothing new.

Part of the reason for intensified activity, it was plain, was competition among unions. Dodging a reporter's questions about the Building Service Union's plans for a nationwide membership campaign, a union official said, "We don't want competing unions to know what we intend to do. Especially, we don't want them to know where we are planning to organize hospitals."

Some hospital administrators were equally timid about talking. In one city where unions have been actively recruiting members all year, hospital people are noticeably nervous: "At a time like this, the thing to do is to keep quiet and let the opposition make the mistakes," one hospital administrator said, "and the less publicity, the better." Union organizers read the hospital magazines, an administrator in another city said, warning a reporter to be careful.

Where resistance to unions is strongest, there is no such fear of publicity. Hospital trustees and administrators in New York City stated their position on union recognition frankly to newspaper reporters from the outset of the dispute, and, during the strike, press conferences were held regularly by the Greater New York Hospital Association. To offset union claims that hospital service had been seriously interrupted, the Mt. Sinai Hospital in New York invited reporters to come to the hospital at any time during the strike and talk freely to employes and patients. Visiting Mt. Sinai when the strike was a month old, one reporter said, "Only the politest murmurings of discontent could be heard."

Most hospital people felt that when a union had done its worst for five weeks and had held up hospital service only to the point of "polite murmurings of discontent," there was more to be gained than lost from publicity. This view was expressed by a newspaperman in Boston when a hospital administrator there would tell him only that the hospitals were "gearing for powerful action" against unions.

"Probably means they're getting ready to make a hell of a mistake," the newspaperman interpreted.

Another argument for publicity was that public sentiment always favors hospitals in a labor dispute. In New York, the striking union claimed "unprecedented support in the press" when newspapers commented unfavorably on hospital wages and the fact that hospital officials refused even to meet with union representatives. As the strike progressed, however, it was clear that the public has little patience with a strike against hospital patients — especially, in this case, when the strike continued after a court had ordered the strikers to go back to work. "The first essential is for the strikers to return to their jobs," said the *New York Times*, commenting on the court order. "They were already in contempt of their humane duty to assure proper care of the sick and the helpless. If they now persist, they are in contempt of court and judicial process as well."

In New York and elsewhere, the strikers not only persisted, they also got rough. A nonstriking orderly at Mt. Sinai Hospital was knocked down a flight of subway stairs and beaten on his way home from work; strikers on a picket line kicked policemen who were trying to quiet them. In Tulsa, pickets linked arms and tried to keep doctors from entering the hospital — a maneuver that was hastily abandoned when an angry surgeon drove his car through the line, scattering frightened and astonished pickets right and left. Last year in Seattle, union toughs smashed hospital windows, used stink bombs, and even threatened to bomb the administrator's car.

As they proved to be in Seattle, these were the tactics of losers. By last month, hospital policy was hardening into solid resistance, and few hospital people were pleading the cause of union recognition, even where unions were already recognized. (Some hospitals had learned the hard way that union appetites are never satisfied; a California local of a maids, porters and culinary workers union which was recognized by hospitals some years ago, for example, is now demanding a closed shop.) Many hospitals even rejected the community board of appeals concept, insisting that by submitting disputes to arbitration hospitals were giving up too much control of hiring, firing and wages. "The Toledo Plan sacrifices more authority than most hospital people realize," said a hospital personnel expert. Hospitals in many areas, and notably where labor disputes were in progress, clamored for a stronger stand against unions by the American Hospital Association, whose position did not rule out collective bargaining but held only that "hospitals must not be compelled by law to recognize and negotiate with a union."

Released in June, an A.H.A. statement used an unfortunate word in declaring an obvious truth: "The best way to deal with this problem is to strike at the causes," the statement said.

Whatever else it had done, the drive to unionize hospital workers by midyear had focused hospital and public attention on hospital wages and working conditions, and these seemed certain to improve as a result. The *New York Times* pointed out that voluntary hospitals lost more than $13 million last year on patients whose care was presumably paid for by the city. Payments for indigents were scheduled for a 25 per cent increase July 1 — an action that owed something, at least, to the labor dispute, which had revealed thousands of employes in New York hospitals were paid less than $1 an hour. "The city's underpayment is helping to bankrupt the voluntary hospitals and force them into inhumane treatment of employes," said the *Times*.

Elsewhere, hospitals scurried to review wages, hours and personnel practices, though some hospital attorneys warned that these 11th hour measures, especially if they were undertaken after union recruitment started, were inadvisable and gave the unions something to talk about. Inadvisable or not, hospitals everywhere were following the A.H.A. admonition to clean house. In a way that was not intended, the turgid boast of a Seattle labor newspaper might yet prove to be true. "Last year's strike against the Swedish Hospital may one day be looked upon as the opening shot in the final battle to bring a decent standard of living to all hospital employes," this said. ■

Here for the first time is the inside

story of what happens when hospitals and

unions collide in controversy

The hospital's side of a hospital strike

Raymond F. Farwell

Swedish Hospital, Seattle, was the scene of one of the longest and bitterest hospital strikes in recent years. The strike, which lasted 84 days (March 20, 1958, to June 11, 1958), was ostensibly conducted by the Hospital Workers Union, Local 301, a subsidiary of the Building Service Employes International Union.

The strike settlement consisted of the following six points:

— The hospital's scale of hours, wages and employe benefits existing at the time of the strike were to be maintained.

— The Seattle Hospital Council rather than individual hospitals was to discuss any questions with the union.

— Employes who remained loyal during the strike, as well as those employed after the strike started, were not to be affected by the return of any strikers. As and when normal vacancies occurred, strikers who wanted jobs were to be offered jobs to fill such vacancies.

— The Toledo Plan was recommended (for details, see p. 76), in effect, this plan permits every employe to decide for himself whether or not he wishes to belong to a union.

— The hospital agreed to establish a conference committee for nonprofessional employes at which the elected representatives were to meet with management regularly to discuss any mutual problems.

— The union agreed to reimburse the hospital for property damages.

What happened before, during and after the walkout is reported here by Ray Farwell, administrator of the hospital, in reply to questions asked by The MODERN HOSPITAL.

What were the first signs or incidents that told you an organization drive by the union was under way among your employes?

There were several preliminary indications:

— A contract recognizing the union was forced under threat of strike upon the Virginia Mason Hospital, a neighboring nonprofit institution, on Aug. 1, 1957. At that time the union announced it would continue its drive for organization on the other nonprofit hospitals of Seattle.

— In September and thereafter, various pieces of printed literature were found about the hospital, in rest rooms, corridors, and on window sills, urging employes to join the union and pointing out what miserable conditions of employment they had under the present nonunion system. Much of this literature is printed at the headquarters of the Building Service International Union in Chicago and bears its imprint.

— During the fall months of 1957, a person who was known to be a union organizer came into the hospital frequently and sat down in the employes' cafeteria at coffee break times where she would engage in animated discussion with groups of housekeeping and dietary employes. It was well known to the executive housekeeper and chief dietitian that this was going on. The activity was kept under observation as far as possible.

With whom did you consult in arriving at a hospital policy?

Consultations were held with the hospital board of trustees and with other hospital members of the Seattle Hospital Council. Prior to capitulation of Virginia Mason Hospital, the Seattle Hospital Council's labor committee had on a number of occasions discussed the developments occurring at Virginia Mason.

In the spring of 1957 an attorney specializing in labor affairs was retained by the Seattle Hospital Council to assist the labor committee in developing a definite policy upon which a stand could be taken. This attorney was available for consultation from that time on and did all the legal work for the Swedish Hospital bearing on the strike.

Did the hospital have a firm labor policy in advance of the actual strike, and what was it?

There was nothing which could have been called a labor policy prior to intensification of Local 301's organizing activities late in 1957. The only policy was one of more or less ignoring unions and over a period of years attempting to keep the hospital wage scales approximately on a par with those in other community industry employing the same kinds of employes (that is, hotels, restaurants, office buildings, and the like). In advance of the actual strike, a policy statement was posted on hospital bulletin boards on Dec. 1, 1957, following receipt of a letter from the union requesting recognition. This policy said in part:

"The management of this hospital fully realizes the right of employes to form associations and in no way wishes to interfere with their efforts in this direction."

(Continued on Next Page)

It then pointed out that the union contract secured at Virginia Mason Hospital had gained nothing in terms of wages and working conditions for the employes of Virginia Mason Hospital. It closed by stating:

"Your hospital's position on union membership is as follows:

"1. Any employe is free to join any labor union; the hospital will never discriminate against union members.

"2. Any employe is also free *not* to join any labor union. *No employe should feel it necessary to join any organization of any kind in order to protect his or her job either now or in the future.*"

This latter sentence was inserted because of threats which had been made to employes that they would lose their jobs as soon as the union contract was negotiated if they had not previously joined the union.

During the strike, "Unfair" signs were plastered on the windows of Swedish Hospital by several men, among them the business agent of a local union.

What preparations were made for the strike?

Early-stage preparations included meetings with the Seattle Hospital Council to formulate what appeared to be a defensible labor policy, plus the regular informing of other hospitals of developments in the situation. A few days prior to the strike a special meeting of the Seattle Hospital Council was called. At this time other members were informed that a strike at Swedish Hospital appeared highly probable within a few days, and that the Swedish Hospital was prepared to accept the strike, provided it would have the complete moral support of the other hospitals. Only one hospital declined to give any such support.

A special meeting of the hospital board of trustees was called on the evening of March 18, 1958, in order to clarify the hospital's policy and make sure the decision to accept the strike was fully approved by all of us and that we were in agreement as to how to proceed. I asked that the board clearly show that a decision was made to proceed with the strike. After some discussion, a motion to this effect was unanimously passed. This gave the administration the sanction it needed to carry out what had previously been a more or less informal attitude by the board that it would be worth accepting a strike in order to maintain our principles.

In the immediate pre-strike period, the following preparations were made:

About two weeks before the strike, the chief dietitian (who purchases all consumable dietary supplies) was instructed to fill her storerooms to capacity, not later than March 18, 1958 (at that time the tentative strike date of March 20 had already been set). The hospital purchasing agent was instructed to bring all general stores up to the capacity of our storerooms by the same date, which he proceeded to do. (In the last two years we have followed a policy of keeping inventories at an irreducible minimum for current operation and, therefore, there was a fair amount of available capacity in the storerooms for this emergency build-up.)

Another step taken was to consult with the business agent of the Operating Engineers Union (with which the hospital had had a contract for many years) and to receive his assurance that there would be no slowdown or work stoppage by his men in the event there was a strike. This, of course, assured the hospital of continued power plant operation. This man at one time had been chief engineer at the Swedish Hospital and he willingly gave us his assurance of coverage. It was only later that we learned that this assurance could not be relied on. Special preparations were made regarding fuel oil. I don't believe we consciously realized this would be any particular problem to us. Normally the hospital's 10,000 gallon fuel oil tank was filled twice weekly, on Tuesday and on Friday. But we instinctively made special arrangements to have our fuel tanks filled to capacity on Wednesday evening about eight hours prior to actual commencement of the strike. This later turned out to be the wisest thing we did during that period.

We also obtained the assurances of our fuel dealer that he would keep us supplied through any eventuality. These assurances later proved to be worthless.

An emergency meeting of the medical staff executive committee was held about 72 hours before the strike. We informed the doctors of the issues and of the fact that we intended to stand firm.

Raymond F. Farwell has been administrator of Swedish Hospital, Seattle, since 1954. From 1945 to 1954 he was at Virginia Mason Hospital, Seattle, in various capacities, including business manager, assistant administrator, and hospital manager. Mr. Farwell is a graduate in public administration of Harvard University. He is president of the Washington State Hospital Association, and is a member of the American College of Hospital Administrators.

On the day prior to the strike a number of employes reported that they had received direct and indirect threats about what might happen to their cars or how rough it might happen to be crossing the picket line. Therefore, I visited the mayor's office and told him of these threats of violence and asked officially for police protection. The mayor assured me that, although the police could not take sides in a dispute, he would see to it that there was sufficient regular police coverage to prevent anyone from being injured by any pickets. In keeping with this promise he arranged for two patrol cars to be present at 5:30 a.m. on March 20, at the actual moment the picket line was set up.

Are there other steps that you now think should have been taken?

Had we been convinced the strike was actually going to occur, we would probably have made advance arrangements with commercial laundries to handle our laundry load. However, the developments in that direction could not have been foreseen. Had we been able to foresee the fact that our fuel oil delivery would actually be cut off, we would have made earlier arrangements to acquire fuel oil trucks. This again, however, could not have been foreseen.

I think we should have devoted a little more effort to discussing developments with our employes. The last act in this direction just prior to the strike was a bulletin issued on March 19 (the day before) stating that strike by the union appeared inevitable, that we had confidence that most of our employes would not desert our patients, and exhorting them to disregard the threats of violence by the union and to stand firmly with us in keeping the hospital in operation.

What are some of the episodes that stand out in your mind from the meetings you had with union representatives?

The first face-to-face meeting occurred on Feb. 11, 1958, with Vivian Feddern, a union organizer who had for some months been meeting in our cafeteria with groups of nonprofessional employes. On that day Mrs. Feddern was observed by the hospital housekeeper to be wandering aimlessly through the obstetrical department on the third floor. The housekeeper asked her to leave at once (acting on my prior instructions) and escorted her to the personnel office, where Mrs. Feddern insisted on seeing someone in authority. I proceeded to the personnel office to interrogate her. Mrs. Feddern met me with a violent complaint about the discourtesy shown by the housekeeper. When I questioned her about her business on the third floor of the hospital she stated she had been up there to visit a friend of hers who was ill. Upon questioning, she was unable to give the name of the friend or the friend's room number. At this point I told her to leave the hospital and not to return under any circumstances. She stated that the hospital, she thought, was a public place, and any one could enter it. I informed her that the hospital was not a public place and that the only persons permitted to enter came by our invitation, and that she had not been invited. She left in considerable embarrassment, and reported to her superiors.

This episode later became known as the "Feddern Incident" and caused me to be attacked bitterly in the union paper. The primary basis of my criticism of her at the time of the interview was that she was suffering from a severe head cold with a running nose and had, nevertheless, ventured into the maternity department, although her background was that of a practical

Timetable of the Swedish Hospital Strike

August 1957 to December 1957

Organization drive among hospital employes launched by the unions. Within this period (from November 1957 to February 1958) union demands were presented to the hospital and preliminary negotiations were conducted.

February 1958 to March 1958

Period of threats against the hospital and final prestrike negotiations.

March 20, 1958

Start of picketing.

March 20 to April 10, 1958

"Battle of the supply lines" was carried on to prevent needed supplies from reaching hospital. Fuel oil supply was seriously jeopardized.

April 1 to April 5, 1958

Period of practical jokes and harassing tactics.

April 5 to May 11, 1958

Period of violence and threats of violence directed at hospital officials.

April 14, 1958

First signs appeared that union was weakening. In an interview with the press, Union President Hooper says that position presents a "hopeless deadlock."

May 11 to June 11, 1958

Period of attrition during which the hospital's position grows stronger and union's position grows weaker.

May 27 to June 11, 1958

Union and hospital enter into final negotiations. Union agrees to reimburse hospital for property damage.

August to October 1958

Post-strike negotiations and establishment of Seattle Plan based on Toledo Plan. (For details of the Toledo Plan, see article by Ray Bruner starting on Page 76.)

Stay Out of Court

An interesting sidelight to our struggle was the fact that we never went to court at any time. A wise attorney who was advising us determined at the outset that this was a war, and as he put it, it would have to be won on the foul line. He steadfastly resisted my pleas that he seek an injunction in order to relieve us of pressure and get us our oil when we needed it. His point was that he would go to court only as a last desperate measure when the hospital was about to close, but until that occurred we would have to run it the hard way. His reason was that if he had gone to court and asked for an injunction and for any reason had been turned down, such a rejection would, in effect, have given the strike the sanction of the court and we would have been licked at that point. It was hard to take at times, but I went along with him and events certainly proved him to be right.

nurse and she certainly knew better.

The second meeting that I remember was held at the Swedish Hospital with Harry Busch, executive secretary of the King County Labor Council; Eugene Hauck, a vice president of that council (as a teamster Mr. Hauck was subsequently dropped from the council on orders from A.F.L.-C.I.O. Headquarters), and Arthur Hare, the international representative in this area for the Building Service Employees Union. Representing Swedish Hospital were Hugh Owens, administrative resident; John Horrigan, personnel manager, and myself.

This meeting had been called by the King County Labor Council as a sort of investigation prior to its sanctioning a strike by Local 301. On advice of our counsel we took a position of offense rather than defense and criticized Local 301 for the following points:

1. The local's notifying the newspaper of strike action pending at Swedish Hospital on Jan. 15, 1958, when from our standpoint discussions had just been initiated.

2. The release of irresponsible literature alleging substantial gains for its members at Virginia Mason Hospital, when in fact no gains were made.

3. The Feddern Incident of the prior week.

The union representatives were then informed of the hospital's official position, which was:

– That we did not intend to negotiate in behalf of only certain departments of the hospital, but that a majority of eligible employes must be involved before we would be concerned.

– That when and if negotiations were instituted, the Seattle Hospital Council would act as our bargaining agent and that we could not negotiate as an individual institution.

The union representatives conceded that our first and third complaints (listed above) showed very poor judgment on the part of the local and that Mr. Hooper, president of Local 301, would be taken to task about these matters.

Five or six days after the meeting, the union newspaper came out with a front page attack on me, for having ejected Mrs. Feddern from the Swedish Hospital, and stated (as usual) that we had refused to discuss anything with them in good faith.

At the insistence of Mr. Hare, I finally consented to have lunch with him and Mr. Hooper on March 7, 1958, which I did as their guest in company with Mr. Horrigan, our personnel manager. The purpose of this meeting was for me to get personally acquainted with Mr. Hooper. It was specifically stipulated that this was an informal lunch meeting, that it was not a negotiation, and that no word of it would be given out to anyone.

Following lunch – during which all of us had some difficulty in talking about matters other than our mutual problems – I pointed out to Mr. Hare that it was unfortunate that Mr. Hooper had got himself so far out on a limb that he could hardly call off a strike without losing face. Mr. Hare replied that this would be easy provided we were reasonable, and the secret nature of our meeting was reiterated. Several days later the union paper triumphantly announced that Mr. Hare and Mr. Hooper had held a negotiation with Mr. Farwell, and had made substantial progress.

I called Mr. Hare by telephone and pointed out that he had violated our agreement not to discuss the meeting. He replied that he was "sorry" and did not know how it had got into his newspaper.

Tactics: The Art of Rolling With the Punches

Although we did not consciously formulate any tactics at the outset, in a few days we did express them verbally and from then on adhered to them consistently. Since the union was the aggressor, we automatically became the defender. We decided to keep this role. Instead of attacking the union or taking positive measures to injure or interfere with the members, we simply went about our business of operating a hospital with as much dignity as we could maintain. Although we attempted to anticipate the next move and thought of the union and to set ourselves accordingly, we waited for it to hand out the punches and then we simply rolled with the punches and, when we could, got in a strategic counterpunch. I think we were able to maintain our dignity throughout, and by so doing we made the union look worse and worse and we gained more and more public respect and sympathy. During the strike we had as a patient on two occasions one very aggressive union business agent in our community. We also had two business agents' wives in Swedish Hospital as patients during this strike. Needless to say these folks came in rather unobtrusively and requested that we not advertise their presence in the hospital.

On Tuesday, March 18, I received a telephone call from Mr. Hare following a final conference with the Seattle Hospital Council at which Mr. Hare was informed that the council was not prepared at that time to negotiate a contract with him.

The conversation over the phone ran something like this:

Hare: I guess you heard what the Seattle Hospital Council did.

Farwell: No, what?

Hare: They turned me down; this leaves me only one alternative.

Farwell: What is that?

Hare: Strike.

A period of silence.

Farwell: I don't think a strike is necessary to get what you want if you go about it the right way, and I think you should consider it pretty seriously before you take a step as drastic as that, with all its consequences.

Hare: I'm going to close that hospital.

Farwell: I don't think you can.

Hare: I've never lost a strike yet.

Farwell: I thought Mr. Hooper was president of Local 301; who is calling the tune, you or Hooper?

Hare: I am.

Farwell: It is rather interesting to me that Mr. Hooper sets himself up as an authority on hospital operation and hospital economics. What is his hospital background of experience?

Hare: Mr. Hooper has never worked in a hospital, but he subscribes to all of the hospital journals and reads them carefully, and, therefore, has a good knowledge of hospital operation.

Farwell: How did Hooper come to be president of Local 301?

Hare: He was elected by a large majority of the membership.

Farwell: Who was running against him?

Hare: No one ran against him; as a matter of fact I think it was quite a tribute to Mr. Hooper's popularity that no one cared to run against him.

Farwell: Yes, it certainly is a tribute to him.

Hare: I'll see you on the picket line.

Would you describe the events immediately preceding the picketing?

On March 19, a memorandum was issued to all hospital employes in the departments involved urging them to remain on the job and assuring them we would never negotiate any agreement which would cause nonunion members to lose their employment. It was stated that because of the need to maintain service to patients, employes who did go out would be deemed to have resigned and would have to be replaced.

Hospital fuel tanks were topped off during the evening. At 5 p.m. the business agent of the engineers union telephoned to state that his men would provide heat only, and that they were planning to do this despite the protests of the leaders of the striking union. This was the first indication that the engineers were going back on their agreement to maintain service.

At 8:30 p.m. the *Seattle Post Intelligencer* editor called me at home to report that official sanction had been granted for the strike by the King County Central Labor Council, after hearing a report by Mr. Hooper, president of Local 301, that the hospital had just fired a number of union members and had offered time and a half rates pay to employes who would cross the picket line. During the next hour I telephoned all department heads at their homes and notified them that the strike was definitely going to take place. The president of our board was also so notified.

Tentative help had previously been lined up from another hospital for the purpose of feeding approximately 100 interns, resident and student nurses that were dependent on the hospital cafeteria. It was agreed with the dietitian that no attempt would be made to operate the hospital cafeteria until we saw where we stood with the employes, and that all available kitchen employes would be assigned to patient food service. The Doctors' Hospital made arrangements to feed our board-

Advice for Hospitals Facing Union Organization

My advice to administrators elsewhere who may be facing union organization drives (and certainly they are going to be facing them in any community where organized labor has a foothold) would be:

1. Make sure that your own position is defensible from the standpoint of the wages and working conditions for hospital employes. If the unions have nothing to sell in the way of real improvement for your employes, they will not be able to recruit any substantial number of members. Among other things, the hospital certainly should have some type of grievance machinery whereby an employe can "get it off his chest" if he feels aggrieved and can look forward to being dealt with straightforwardly and fairly.

2. Keep the public informed of the good working conditions that do prevail in the hospital.

3. In a community with two or more hospitals make sure that you and your colleagues have close rapport and that you are prepared to act on a joint or a group basis in the case of any threats.

If administrators will keep these facts in mind, will not allow themselves to be intimidated, and will remember that in general the union tactics are to play a game of poker, the administrators will not let themselves be bluffed, and will come out all right.

ers, which meant a walk of approximately four blocks for each meal.

About 6:30 a.m. on March 20 it was discovered that someone had cut off steam to the hospital laundry sometime after midnight. While this matter was being negotiated, the laundry manager, John Horrigan, rented a large truck and made arrangements with one of the commercial laundries to process our linens.

On his first trip to the laundry he was followed by several carloads of pickets (under the leadership of one of the hospital orderlies) who entered the laundry plant and attempted to persuade the laundry employes to refuse to handle Swedish Hospital laundry. The laundry management got in touch with the Laundry Workers Union, and obtained clearance to proceed with this work with the stipulation that, although Swedish Hospital was doing all the hauling, union laundry truck drivers would be paid a commission as if they had actually been hauling the laundry. This cost, of course, was passed on to Swedish Hospital.

One thing that stands out on this first day was the flood of job applicants who appeared at the hospital personnel office. So many applicants arrived that it was necessary to put additional staffing in the personnel office to handle them. Because of the involvement of three shifts, plus days off, it was several days until we could determine exactly how many employes actually had left us. Nevertheless, by the end of the first 30 hours of the strike, we had already hired 30 new employes.

On March 21, someone turned off the steam line from the boiler room to the hospital kitchens. Within a few minutes after this was discovered, the steam was turned back on and an armed guard was placed on duty at the valve. This valve was guarded by an armed guard day and night for the next six weeks.

On March 22, the hospital board president received a call from the business agent of the engineers union stating that he was being forced by pressure from the striking union to cut off steam to the hospital kitchens. We ignored this remark and continued to operate the kitchen and maintain the guard.

A decision, however, was then made and carried out to contact navy sources for possible retired navy water tenders (boiler men) who might be willing to come to work for us. Through this source several men were located and in the next few weeks three of them were brought into the hospital without being identified to the union engineers. These men were told to observe the boiler operations as best they could, but to spend their time changing light bulbs and puttering around on minor maintenance jobs. The purpose, of course, was to protect us and ensure continued operation of the plant, in the event the engineers should happen to walk out.

Would you describe the actual picketing?

At 5:30 a.m. on Thursday, March 20, the picket line headed by Mr. Hooper arrived on the scene. All of us in the hospital management were on hand in the hospital. There was, of course, considerable excitement. We spent an hour or so making sure that everything was going smoothly and that nobody was unduly upset. The actual picketing usually consisted of two pickets standing four-hour watches at each of the four entrances.

At 7 a.m. the operating engineers arrived to take over the day shift and were blocked by the picket line.

At this point I went to the sidewalk to discuss the situation with Mr. Hooper, who was in charge of the picket line. It was agreed that the boiler man for the day shift would be permitted to enter the hospital and keep the plant operating but that no maintenance men would be permitted inside, and provided that we did not attempt to turn on the laundry steam, the boiler man would be left on his job. If we did attempt to operate the laundry, the boiler man would be forced by the pickets to leave.

At this point I told Mr. Hooper that his attitude toward sick people in a hospital was not a very humane one. His reply was — "Don't blame me, blame those stupid doctors who refused to remove their patients from the hospital when I warned them."

On Saturday, March 22, two men appeared outside my office. One was Mr. Hare, in charge of the strike, the other was James Estep, international representative of the Operating Engineers Union, who asked for a general conference on the subject of the steam plan operation and the hospital laundry. I refused to confer with Mr. Hare, but agreed to meet Mr. Estep, and we held a 20 or 30 minute conversation over coffee in the hospital cafeteria. Mr. Estep appeared to be a very reasonable man, whose men had been caught in the middle of a difficult situation. The engineers wished to keep the hospital plant in full operation and stay on their jobs. The striking union would not permit them to do so. The suggestion had already been made that the operating engineers would be forced to leave entirely.

Mr. Estep assured us that this would not happen, and said that if he personally had to stand watches on our boiler in order to keep the hospital warm he would do so. Two days later Mr. Estep was instrumental in arranging a conference of top ranking labor officials in Seattle to further discuss means of ending the strike.

On Monday evening, March 24, a secret meeting was held in a small private dining room of a downtown

(*Continued on Page* 124)

Make Your Position Unmistakably Clear

When negotiations fail and a strike is imminent, *make your position of resistance unmistakably clear*. Be sure that hospital employes know that management will stand firm. Be sure that they know they will be replaced if they abandon their job of caring for the sick.

We made no belligerent noises and did not commit ourselves to any action until the day before the actual strike. Very possibly the union interpreted our actions as a sign that we would capitulate at the last minute.

This is substantiated by a conversation I had on the picket line with Mr. Hare, a union leader, about one week after the strike started.

Farwell: Hare, I thought you were bluffing. I didn't think you'd really do this to us.

Hare: We thought you were bluffing. We didn't think you'd let us do it.

After many months of resistance, Montefiore Hospital negotiated a union contract. The hospital's director tells how it was done, and why

Why we signed a union agreement

Martin Cherkasky, M.D.

IN MARCH 1959 Montefiore Hospital signed a union agreement with Local 1199, Retail Drug Employes Union (Hospital Division) A.F.L.-C.I.O. This agreement covered more than 600 of the 900 people[1] in the following categories: nutrition department, laundry, building service department, attendants, porters, maids, laboratory helpers, engineering department, pharmacists, messengers, elevator operators, storeroom employes, technicians, guards and watchmen, switchboard operators, clerical employes. (No supervisory and certain other special category personnel is involved, *e.g.* employes in the accounting department, employes in the administrator's office, and so forth.)

The basic condition which brought Montefiore Hospital to the attention of the union (even though the situation at Montefiore was comparable to that at other New York City voluntary hospitals) was the seriously depressed wages of most of our hospital workers, particularly those classified as nonprofessional. Even when this classification was broadened to include technicians, the scales were not comparable with the scales in industry.

For example, the lowest hiring scale for unskilled workers, such as porters and maids, was $147 a month, or roughly $35 a week. While it is true that such workers received frequent increments, it is obvious that at the starting salary a worker with a family was not getting a living wage. A significantly higher scale was being paid to the same kinds of workers in the New York municipal hospitals. There, the starting pay was almost $20 a week higher than that paid in most of the voluntary hospitals.

Low Pay Attracted Two Groups

The low pay scale attracted primarily two groups of workers: untrained people and newcomers to New York, mainly Puerto Ricans and Negroes. These recent arrivals in the community take these jobs as a first foothold in the city. As soon as skills are acquired and English language difficulties are overcome or both, they leave for better paying jobs. At Montefiore this resulted in an annual turnover rate as high as 300 per cent – particularly in the dietary and housekeeping departments, which absorb the major number of the low paid employes. This turnover was not materially affected by other conditions of employment, which were surprisingly good; sick leave, vacation time, holiday time, and other benefits were all comparable to those in industry. Of course, none of these fringe benefits could make up for lack of take-home pay.

The situation that existed at Montefiore Hospital was, in general, characteristic of all voluntary hospitals in New York City. The situation was probably more difficult because of the expensive training and research programs being carried on in a teaching hospital such as Montefiore. During 1958 an operating deficit of approximately $1.3 million was incurred at Montefiore Hospital, after income from patient sources. It is particularly staggering to note that this deficit occurred despite the inadequate wage rates for nonprofessional help. The deficit would have been approximately doubled if the hospital pay scales were comparable to those that applied in industry.

The basic reason for this operating deficit was that two of our three major sources of support for patient services did not meet the bill. First, New York City paid us $16 a day for general medical and surgical care and $7.50 a day for tuberculosis care. We provided about 90,000 days of care to patients supported by the city at a cost of approximately $26 a day, or a $10 a day deficit for medical and surgical city patients and a greater deficit for the patients with tuberculosis. The deficit incurred by the care we provided to city and tuberculosis patients was close to $1 million. In addition to this, the hospital's average Blue Cross income was a few pennies over $29 a day while the average cost for the Blue Cross patient was a few pennies over $32 a day. The more than 80,000 Blue Cross semiprivate days we pro-

[1]Total paid hospital staff is approximately 1600.

Dr. Martin Cherkasky is director of Montefiore Hospital, New York.

vided produced a loss of more than $250,000.

The administration of this hospital faced the same problems as virtually all voluntary hospitals. The advances of medical science demand more and more expensive equipment and more personnel with many more skills. Open heart surgery alone at Montefiore Hospital involves tens of thousands of dollars' worth of equipment and dozens of people.

In this kind of dilemma, administration is faced with two choices. Should the administration put its limited funds into adequate salaries and thereby fail to make full use of the life saving devices which medical science provides? Or should it put money into all the new technics in science which the community demands and needs and thereby deprive particularly the nonprofessional worker of an adequate wage? We have perforce chosen better medical care, but noble as our purpose is, it is unfair that hospital workers must bear the burden of inadequate financing.

This, then, was the situation we faced: workers inadequately paid and bearing resentments toward the institution in which they worked; hospitals seriously short of funds and unable to meet simultaneously both their primary duty of providing medical care and their duty of adequately compensating the workers.

Two Premises for Resistance

Through a period of many months Montefiore Hospital resisted the efforts of Local 1199 to force it into collective bargaining. Our resistance was based upon two premises:

1. Organization by a union was meaningless without some method by which the hospital could provide funds to cover potential wage increases.

2. Those responsible for the operation of the hospital were deeply concerned about the effect of organization upon already difficult hospital operations. Would union activities so interfere with management as to make operations more difficult than already was the case? Would the hospital be subject to strikes and slowdowns which, because of the effects upon patient care, would place a serious moral burden upon both union and hospital management?

One of the first breaks in the situation was the agreement by the city of New York, effective July 1, 1959, to provide a $4 increase per medical and surgical case, bringing the total to $20 per patient day. Our board decided that the monies received through the city increase would be allocated to all the workers and not just to those for whom the union was waging its fight. The mayor in turn insisted that the hospital settle its conflict with the union in some way.

The first step was to determine whether the union represented the workers it claimed. On the next to the last day of 1958 an election was held under the auspices of the state labor relations board. Of approximately 900 eligible workers, about 600 voted for the union, some 35 or 40 voted against the union, and more than 250 abstained.

On Jan. 1, 1959, the lengthy, laborious and painful business of negotiating a contract with the union was begun. Very few people in administrative roles in hospitals are qualified by training to deal with union matters. One of the wisest steps that Montefiore Hospital took was to engage a high quality labor relations counsel who guided us through the difficult time of negotiations. As a matter of policy, the president and the director of the hospital were not involved in the negotiations. Our lawyer, the head of the personnel department, and the associate director for fiscal affairs, who ultimately would be responsible for dealings with the union, were the day-to-day negotiators for the hospital. It was only during the final critical stages when policy decisions were to be made that the director and president became involved. After numerous, often heated, lengthy and debilitating sessions a union contract was finally agreed upon. We believe that the contract is one which represents a reasonable step forward for the workers and one which we hope will not adversely affect hospital operations. The essential features of the contract are:

1. A $10 across-the-board increase for the people in the bargaining unit. As a matter of policy, however, the same increase was provided to all workers whether or not they were in the bargaining unit.

2. A further increase of $10 a month effective July 1, 1959.[2]

3. An additional $10 increase July 1, 1960.[2]

4. A two and one-half year contract to run until June 30, 1961.

5. Union agreement to a no-strike clause.

6. During the last year of the contract, a fund to be set up by the hospital to extend sick benefits by $1 per month per employe in the bargaining unit, which was rounded out to a figure of $10,000 per year beginning July 1, 1960.

7. Management to retain full rights in regard to allocation of work. Seniority still exists, but there will be no seniority between shifts.

8. In regard to questions of professional competence, hospital decisions to prevail.

9. Grievance problems to apply only as to interpretation of the contract.

We have had little more than two months of experience under this contract. To date there have been no problems. However, it is too early to say what the long run will bring. We are hopeful that maturity and understanding on both the side of hospital management and union leadership will make this arrangement work.

It is obvious that unionization or no unionization, the hospitals are going to have to pay workers an adequate wage. These wages will have to be comparable to those paid for the same jobs in industry. Hospitals will have to stop hiding their light under a bushel and find ways and means of bringing to the community an awareness of how hospital income is spent. It should be made clear to the public that increased hospital costs resulting in increased hospital rates are the result of the enormous complexity of medicine.

The hospital should not apologize for high rates when actually the rates are not high enough! If the people of our country realize what they are getting in return for each dollar spent and know that it is their very lives that they are insuring when they pay adequately for hospital care, I cannot believe that we will not receive sufficient funds. When this happens, hospital administration will not have to look back as I must to the days when hundreds of employes were forced to bear the burden of inadequate hospital financing. ■

[2]These two increases depend upon the increase of $4 per patient day from the city effective July 1, 1959, and an additional $2 increase in rate on July 1, 1960, which will bring the city rate for patients in voluntary hospitals to $22 a day.

A leading spokesman for organized labor describes what unions want—and don't want—from hospitals

The case for unionization of hospital workers

Nelson H. Cruikshank

HOSPITAL administrators currently are laboring with the thorny problem of whether or not their employes should be represented by unions in collective bargaining.

Actually, the decision is not theirs. It is one which can, should and is being made by the workers themselves.

Once the majority of a hospital's employes decide they want a union, the conscientious administrator — whether or not he agrees with the decision — has no honorable alternative but to negotiate in good faith with the chosen representatives of his workers.

And once the basic step of union recognition has been achieved, the union has no honorable alternative but to refrain — so long as methods for resolving differences are provided — from any action which would impair in any way the hospital's humanitarian mission in caring for the sick and injured.

There is no law that requires a private, nonprofit hospital to engage in collective bargaining.

But neither is there any law which forbids it.

At issue is nothing more or less than the moral code by which most of us try to live. To undergird this moral code, there is the tremendous influence of community opinion which plays such a major role in the practical application of union-management relations — and neither side can truly afford the luxury of ignoring or defying the power of public opinion.

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It is my hope that hospital management will approach the inevitable age of collective bargaining with a feeling that it is a logical and desirable development in an era of group communication, rather than with a feeling that organized labor has a pistol at its head.

When unions were struggling over the years to win recognition from private industry, it always came as a shock to the average employer to discover that his employes really wanted union representation.

The industrialist liked to believe, and often managed to convince himself, if no one else, that he knew each of his employe's needs and interests; and that a union would only interpose some shadowy "outsider" between his benevolent management and the members of his "one big family," even though that "family" often numbered hundreds of thousands.

The hospital administrator who imagines he can maintain effective communication with his employes on an individual "my-door-is-always-open" basis lives in a dream world. He may find it a pleasant world, while it lasts, but not real.

The simple fact, whether we like it or not, is that we do deal with each other through organizations and groups. Hospitals do in fund raising, and they do in arranging for an insured basis of payment for care.

Dealing with employes through the organization of their own choosing is another facet of the group pattern.

"Collective bargaining," writes President Ray Amberg of the American Hospital Association in the *A.H.A. Journal*, "has arisen as a desire for a democratic method to solve the problems of employer-employe relations principally due to the lack of proper functioning of the direct employer-employe method."

He adds that hospitals "no longer possess the right" to deny workers the "privilege" of collective bargaining.

No Guarantee Against Ulcers

Naturally, collective bargaining will not solve all of a hospital's personnel problems, nor will it keep personnel directors from getting ulcers. Despite the necessary ingredients of sincerity and good faith on both sides, there will be strong differences of opinion and frayed tempers before agreement is reached. But there will exist — and this is important — a forum for resolving these differences. As any experienced personnel director can attest, responsible unions provide a safety valve which helps to settle legitimate grievances promptly, weed out the irrational gripes, and clear up honest misunderstandings.

"But hospitals are different!"

So goes the arguments of those who assert that unions have no place in a hospital because every job, no matter how lowly, is essential to the providing of vital services to the sick.

Isn't this argument an application of a double standard?

No administrator would expect the physician or surgeon to work for less than the going rate in his profession,

yet too often they tell the $35 a week elevator operator, attendant or laundry worker, in effect: "Your services are so essential you should work for less money and fewer benefits than persons doing less important work in less socially useful industries."

While hospitals are primarily humanitarian, some aspects of their operations are purely business in character.

As I read advertisements in hospital and medical journals — especially when I note prices — I see no evidence that business concerns which sell to hospitals operate on a humanitarian basis. I can't imagine an administrator appealing to an equipment manufacturer or drug concern to sell his products to the hospital below cost because the hospital is a humanitarian institution.

It is equally true that some hospital jobs are among the essential business operations of the institution. This is nonetheless true simply because the law says a hospital is not "engaged in commerce."

It is a tragic thing when a person works at a job simply because he has to earn a living, and the job has no meaning beyond the weekly pay check. Every job should have meaning and significance in terms of its economic and social contribution, whether in a hospital or a button factory.

But the effort to instill in the worker's mind a sense of "participation" in a socially useful undertaking will have a hollow ring as long as it is offered as a substitute for decent wages and for working conditions that recognize the individual's true worth and dignity.

The emotional heart of the argument against union recognition lies in the belief that this will somehow make strikes against hospitals "inevitable."

As a matter of fact, they are more likely to be inevitable if unions are not recognized — for then there will be no machinery for workers to bring their problems and proposals to management through their chosen representatives.

Ironically, the much publicized New York hospital strike, which pulled the whole discussion of unions in hospitals out of the academic field and into the headlines, came about solely because of failure to recognize a union — a union which has repeatedly declared its willingness, if recognized, to sign a binding no-strike agreement.

At two hospitals which recognized the union and accepted the Twentieth Century concept of employer-employe relations, there has been no strike.

And Dr. J. A. Katzive, executive director of Maimonides Hospital in Brooklyn, which has had a contract with the union for 10 years, has declared: "We've had absolutely no problems at all. Relations with the union have been entirely satisfactory."

Even in the tension and bitterness which inevitably resulted from the refusal of the other hospitals to sit down and talk with the union, the strikers have made it clear they are available for emergency duty in any case involving a patient's health.

The same organized labor movement which unites so solidly in support of the right of hospital workers to union representation would be equally united in condemning any union which bypassed mediation or arbitration and violated a no-strike pledge.

Because conflict makes news, hospital administrators with no firsthand knowledge get a distorted picture of labor from the newspaper headlines.

But when purely emotional issues are put aside, the basic argument against union recognition becomes a dollars-and-cents issue.

Granted, says the hospital administrator, many of our employes are poorly paid. We can't afford any more money. If his is a voluntary hospital he will point to the dependence on fund drives to close the gap between revenues and expenses.

Union organization — let's face it — will increase wages and, consequently, costs of hospital care.

Inevitable Wage Increases

Some wage increases are inevitable, union or no union. As Dr. Russell A. Nelson, director of Johns Hopkins Hospital, has said: "That involuntary philanthropist, the hospital employe, has apparently rebelled at his traditional role of subsidizing hospitals. Today he will and does leave us for the office and factory if we offer him no more than the opportunity to contribute his services to a charitable institution at a reduced rate."

If the cost of running a hospital goes up because it starts paying decent wages, this is one of the facts of life — both for the administrator and the community at large.

That community includes the other organized workers, whose trade union movement has been a leader in developing the broad base of community support necessary to sustain the many worth-while charitable undertakings.

Organized labor has always stood ready to do its share. But isn't it asking too much to approach labor for support at the same time that the humanitarian institutions are fighting the very foundation of trade unionism — recognition and collective bargaining — with the same tired arguments used by the industrialists of yesteryear?

Organized labor often speaks of "democracy in the workplace." To its millions of members, this phrase can be translated to mean a voice in working conditions and a sense of human dignity and respect on the job. Hospital employes can hardly be blamed if they, too, aspire toward these objectives.

It is hard to believe that any carefully considered "principle" can serve to deny these hospital employes the same rights presently enjoyed by millions of other American workers.

No Automatic Right To Strike

I would reiterate that the right to a voice in the conditions of employment does not automatically bring with it the right to strike. It does mean, however, the recognition by a hospital of the union of its employes; and it does mean that the administrator will meet with the union and resolve worker problems.

Hospital workers, it seems to me, have a right to seek such a relationship as the legitimate alternative to what otherwise would be a hat-in-hand approach at the open door of the administrator's office.

To say otherwise is to support the contention that hospital workers are somehow "different" — that in the name of dedication, they must forsake decent working conditions for themselves, and decent living conditions for their families.

If workers are to be dedicated to the institution where they are employed, this dedication cannot be used solely as a symbol of sacrifice. It must bring with it some advantages.

To tell today's hospital worker that he must be denied the opportunity to bargain collectively for these economic and social advantages is to inform him that he is a second-class — although dedicated — citizen. ■

Professional as well as nonprofessional employes are part of the Minnesota story on hospital unionization. Here's a report on how things are working out

They live and learn with unions

Donald Wood

IN MINNEAPOLIS and St. Paul, 27 of the 30 nonfederal hospitals have at least one labor contract covering employes. This means that 90 per cent of the hospitals have a labor agreement of some kind. This is a record that we in the Twin Cities think is most unenviable.

What has happened in the Twin Cities to make it such a highly union-organized hospital area?

The history of the labor relations problems of Minnesota hospitals, and specifically the Twin City area, goes back to 1939. In that year the Minnesota legislature passed the Minnesota Labor Relations Act. To a large degree, this act has aided union organization. This legislation has made any working individual a possible union member. The law has also made rules and regulations which govern all facets of labor relations. But, even within the environment just described, it was not a foregone conclusion that the hospitals of the Twin Cities would be highly unionized.

The laws of Minnesota had nothing in them that would be construed as either exempting hospitals or including them in the act. In 1941, a local of the building service union began organizing hospitals in the Twin Cities. The activities began in Minneapolis and with three hospitals. This was approximately two years after the legislature had passed the laws covering labor activities. There was a strike for recognition, and the state supreme court said that the language in the law did not exclude hospitals from collective bargaining; therefore they were covered under the state labor relations law.

Following the court's decision, certifications through the state labor conciliator's office were procured by the union in three Minneapolis hospitals. These certifications were obtained by electing a bargaining representative. From this start in 1941 until the present, the union has grown from a position of representing the employes in three hospitals to representing the employes in 18 hospitals in Minneapolis and St. Paul. All of these representations have come from certification elections except two in which a voluntary certification was made by the hospital of the union and its representation of the employes of the hospital.

At this point, the first ingredient basic to hospital organization has been described – that of legislation and its position with respect to hospitals.

A second factor in any organization attempt is that of a bargaining representative interested in the employes. Most often this representative of the employes will be organized labor. In the incident described, an A.F.L. local had interested itself in a group of hospital employes they chose to call "nonprofessional" employes. This union local wanted to represent as many of the lower income group of hospital employes as possible. Workers presently covered by this union include nurse's aides, maids, laundry employes, janitorial staff, elevator operators, dietary employes, and others.

Another group of employes covered by a union contract is the engineering staff – the boiler room crew. This is a single group of employes, all holding the same job assignments. Again, primarily A.F.L. affiliated unions cover these employes.

Nurses Negotiate

Two other labor contracts are commonly found in the Twin City hospitals. The groups writing the contracts would object to being called "labor unions." But, the two associations responsible for and writing these contracts do act as bargaining agents. The Minnesota Nurses Association has 18 contracts with Twin City hospitals. There is one master contract covering all hospitals in the Twin Cities, but individual contracts are signed by each hospital.

This association negotiates contracts throughout the state, and prob-

Condensed from a paper presented at the Middle Atlantic Hospital Assembly, 1959.

Mr. Wood is executive director, Twin City Regional Hospital Council, St. Paul-Minneapolis.

IN MINNESOTA, NO-STRIKE LEGISLATION TURNED INTO A MIXED BLESSING

ably has contracts with 50 hospitals in Minnesota, including those in the Twin Cities.

A practical nurses association also negotiates agreements between licensed practical nurses and hospitals of the Twin Cities. The Licensed Practical Nurses Association does not do much organizational work outside the metropolitan area.

These are the four basic areas of union organization present in our area of the country.

The organizations representing hospital employes as bargaining agents have therefore covered a majority of hospital employes. The largest groups not covered by contracts are the office workers and ancillary service workers.

Surprisingly enough, all of the bargaining agents have been interested in supervisory personnel as well as the general employe. This is unusual to a union organization or a bargaining agent. The groups in question include head nurses, assistant department heads, and supervisory engineers. I mention these as important areas to be aware of in dealing with any organization representing employes.

A third, and very important factor in the organizing of an employe group, is that of the standards of employment that exist in the industry. What are the personnel policies? Are they realistic? Do they at least meet standards of wages and fringe benefits in the community — wages and fringes for like jobs or like employment?

The Twin Cities, like most hospital communities of 15 or 20 years ago, did not have very realistic personnel policies. They were behind the rest of industry or service organizations. Hospitals were not meeting the wage patterns of the community.

At this point, what I believe to be the three most necessary ingredients to the organizing of an employe group have been fulfilled. These are: permissive legislation, interested individuals or associations that want to represent an employe group, and an industry with substandard wages when compared with the rest of the community. While it most certainly does not take all of these three factors to have attempts to organize hospital employes (as the people of New York City know well), the combination of all three will certainly result in employes being represented by a third party — a bargaining representative.

To review a bit more of the history of the Twin City area, before getting into specifics of our present relationships, it should be noted that a no-strike law was passed by the Minnesota legislature in 1947. This was just eight years after the passage of the original labor relations act. By this time, the legislature had recognized the need for special legislation covering hospitals. The no-strike law is known in Minnesota as the Charitable Hospitals Act. This act was drawn and presented in order that strikes would be outlawed with respect to hospital employes. But, in legislative matters, it was imperative that a fair exchange be given in lieu of this right to strike.

The quid pro quo in this matter was the right to compulsory arbitration. This is *not* conciliation, this is *not* fact-finding, this is compulsory arbitration — the results of which are final and binding upon the parties which enter into the arbitration proceedings. This was the law as it was passed in 1947. In 1951, there was a strike against the hospitals of Minneapolis. An injunction was obtained and a district court judge rendered an oral opinion that the Charitable Hospitals Act, the no-strike law, was unconstitutional.

For two years, the matter was seemingly settled.

But, in 1953, there was again a threat of strike. The strike notice followed conciliation meetings which were unsuccessful. At the time the strike notice was filed an injunction was obtained from the district court in order to prevent the strike. The matter was heard at the district court level and certified to the state supreme court by the district judge.

In April 1954, the Minnesota supreme court upheld the Charitable Hospitals Act and broadly interpreted the act for the benefit of the parties living thereunder. It interpreted the law stating "maximum hours of work and minimum hourly wage rates" as all cost conditions of employment. The act made all cost conditions of employment subject to compulsory arbitration.

The state supreme court did one other thing. It said that the matter of union security, union shop or closed shop, or any matter of union security, was not arbitrable under the act. It also said that the assignment and the direction of a work force with functions bearing directly upon the welfare of the patient was too vital to be a matter of compulsory arbitration and it was to be a prerogative of management.

Is "no-strike" legislation an answer to strikes in hospitals? Yes and no. Yes, it does prevent strikes. And no, it is not the only answer. Compulsory arbitration is a difficult problem. It often makes negotiation and conciliation more difficult. There are often many barriers set up by legislation that are not helpful to good relationships between employer and employe.

With respect to the no-strike law, the Minnesota Hospital Association has adopted the following as one of its basic principles:

"We represent an area which has been very conscious of the rights and privileges of individuals and of organized labor. Our hospitals have had many dealings with representatives of organized subsidiary and organized professional groups. We have supported and fully recognized the rights of employes to organize and to bargain collectively with various hospitals. Mindful of our deep obligations to our patients we have consistently opposed the right of any organized group to strike against any hospital.

(*Continued on Next Page*)

MINIMUM PAY IN MINNEAPOLIS-ST. PAUL HOSPITALS IS $1.33½ PER HOUR

There is at present on the statutes of Minnesota a no-strike law for hospital employes. In this law there is a provision, which we wholeheartedly support, for the lawful arbitration and adjustment of any disputes regarding wages and hours which have occurred between hospitals and the various unions . . . ."

Loyalty a Problem

I do not know whether employe-employer relationships in the Twin Cities are now better, worse or the same. But I do know that often many employes, instead of being responsible to the patient and the hospitals, are responsible only to a third party — their bargaining agent.

This is a basic problem. The loyalty of employes to the hospital and to the patient, of course, is most necessary for good patient care.

With very few exceptions, wages and fringe benefits of hospital workers in the Twin City area are high when compared with most hospitals in the United States. Why? Primarily because of the activity of the bargaining groups mentioned. For example, the lowest paid worker in the hospitals in Minneapolis and St. Paul receives $1.335 per hour ($231.36 per month). Salaries and wages make up approximately 70 per cent of the total hospital expenses. Costs are close to $40 a day — in some cases more than $40. Of course, with salaries being as high as they are, the cost per patient day is high. This makes the tough job of public relations a more difficult one.

A contract governing wages and fringe benefits determines the personnel policies for the group of workers covered by the contract. But personnel policies written by contract cover only those employes in the bargaining group. Therefore, hospitals having both noncontract people and one, two or more groups covered by agreements will have different personnel policies for different groups throughout the hospital. Otherwise, the hospital will necessarily have to follow contract terms when considering policies covering employes not in bargaining units.

Also, personnel policies decided by contract terms are policies determined by negotiation, conciliation and arbitration or both and therefore sometimes are formed and executed under duress.

This means that while the contract often writes most personnel policies, they are not necessarily good. To make a change in existing contractual conditions is often a difficult, if not impossible, job.

What do these things mean? Directly they don't affect hospitals outside the Twin Cities. But indirectly, these conditions affect almost every hospital in the country — primarily those in metropolitan areas. Unionization has taken place in almost every industry and business in our country. It will expand in the hospital field just as it has expanded in all other fields of work. This expansion is *not* inevitable, but it will take place because organizations are working toward this end and hospitals, in many cases, are doing nothing to prevent it.

The cost of hospital care will rise when or if organization of employes (through unions or association bargaining groups) takes place. Wages and fringe benefits will rise, or the organizations have no reason for being. With the rise in wages, and the attendant rise in the cost of hospital care, will go certain other things that are inevitable with employe organization. A lack of flexibility of employes, both as to hours of work and in the jobs performed by an employe, is often the result.

Some of the Problems

For example, the nonprofessional employes union in the Minneapolis-St. Paul area has for many years sought to obtain a 40 hour week, five days, Monday through Friday. Of course, the real reason for this request is to obtain overtime or premium pay for week-end work. In the late 1940's a fact-finding commission even stated that employes should work a five consecutive day work week with two consecutive days off and at least every other Sunday off. Such a schedule means that there would never be anyone working on Sunday and not more than half of the work force working on Saturday and Monday. This, of course, is an impossible situation and was not adopted by the hospitals. Scheduling for 24 hours a day, 365 days a year, like many other things in the operation of a hospital, is a difficult and complex problem. Such problems create many difficulties and confuse those who do not know or understand the complexities of hospital operation.

Employe organizations are also interested in "tying" an employe down to one job with little or no ability to shift the employe to other jobs or even to other areas of the hospital. Through his employe organization or union, the employe often tends to resist change — even change for the better.

Another problem of unionization relates to seniority. A union or employe association is interested in getting better jobs for the individuals. They are not as much interested in standards of qualifications necessary to do the job. They are interested in seniority — or job tenure — and will go to many lengths for recognition in this area.

It is most important to state here that I am not a "union breaker." I am not anti-union. I know the history of unions in our country, and know what they have helped do to raise the standard of living for the working man. I am merely reporting what has happened in our area with unionization in hospitals. It is my opinion, however, that the hospital field — because of its responsibility for care of the sick and injured — is not the place for strong unionization. It is a field for devoted employes — employes who are interested and well trained to meet the needs of our business — the patient. ■

Conceived as a means of settling a strike,

grievance procedures agreed upon in Toledo are

setting a pattern for many communities

"Toledo Plan" supported by hospitals

Ray Bruner

TOLEDO, OHIO. — Established in 1956 to settle hospital labor grievances, Toledo's community board of appeals has accumulated a growing reputation throughout the country as an ideal organization for that purpose.

In Toledo, however, it has had very meager publicity, with every indication that few inhabitants of the city except hospital employes, union leaders and hospital administrators know very much about it. This is chiefly because it has had nothing to do.

Although the board is supported by both labor union leaders and hospital administrators, one labor leader doubted its value so long as only a few hospital workers are organized.

John W. Richards, general secretary of the Toledo Central Labor Union (A.F.L.), contended that some individual workers might find it difficult to carry their grievances to the board. And, if they did, he said, "their jobs might be in jeopardy."

The community board of appeals was set up in a cooperative effort of representatives of the hospitals, unions and the public after a seven-week strike of members of the Electrical Workers Local, employed as maintenance workers at Toledo's Mercy Hospital. The idea of the board was conceived not only as a means of settling the strike but also to prevent further difficulties of this type in the future.

The board has met only once since its inception. The meeting was for the purpose of organizing. Two members were named to represent the unions in the Toledo area, two to represent the administrations of seven of the city's general hospitals, and two to represent the public.

One of the public representatives, Norman J. Kirk, president of the Toledo Pipe Threading Co., was named chairman. The other, Edward Cheyfitz, former Toledo attorney who moved to Washington, died last month. His successor has not been named. Mr. Cheyfitz was chiefly responsible for the idea of creating the board.

The strike at Mercy Hospital began when 11 maintenance workers walked out to gain recognition. As the strikers picketed the hospital, a large number of building trades workers on the institution's $4 million addition walked out in sympathy. Not wishing to jeopardize the hospital's operation, the strikers permitted union truck drivers to go through the picket line without any difficulties.

Negotiations to settle the strike continued without apparent results until the idea of the organization of a board of appeals was suggested.

At a meeting where the formation of the board was agreed upon, both the union leaders and the hospital administrators drew up policies under which each group would cooperate.

The policy suggested by the hospital administrators contained the following provisions:

1. The hospitals recognized that, while their primary duty is to their patients, they have "basic obligations" to their employes and to the public.

2. The hospitals also recognized the right of any employe to join a union without being subject to discrimination because of his union membership.

3. The hospitals agreed to the final authority of the appeals board, and, in addition, agreed to provide employe grievance procedures, with employe representatives elected by the employes, and with a right to review by a committee from the respective boards of trustees or advisers of each hospital.

4. The hospitals recognized it was their duty to pay adequate wages and to make appropriate provisions for additional employe benefits.

As to their side of the bargain:

1. The unions recognized that the care of "the sick, the injured and the dying" may be the function of the hospitals, "but it is also the responsibility of every citizen."

2. The unions agreed that, as a citizen first, the unionist "knows that the collective bargaining of a commercial enterprise cannot be transplanted to a hospital."

3. The unions agreed that strikes, work stoppages and slowdowns in hospitals "can become matters of life or death," and "no responsible unionist can, therefore, talk of strikes or slowdowns in relation to hospitals."

4. The unions accepted the statement of the hospitals that union membership will not be the basis for discrimination, "as well as a plea for employe representation in grievance processing and the establishment of a community board of appeals."

Members of the board representing the hospitals are Msgr. Robert A. Maher, diocesan director of Catholic hospitals, and Wilson L. Benfer, superintendent of Toledo Hospital. The

Mr. Bruner is science editor of the *Blade*, Toledo, Ohio.

and labor

labor representatives are Richard Gosser, U.A.W. international vice president, and Lawrence N. Steinberg, president of the Toledo Teamsters Joint Council.

Each participating hospital that has agreed to cooperate with the board and abide by its decisions has set up a standard grievance procedure.

In commenting on the board at the time it was formed Msgr. Maher said "actually, if the procedures work out as we think they will, this board will have very few meetings."

Mr. Richards said there might be a possible explanation of why Msgr. Maher's forecast might be fulfilled.

"I doubt, when there are grievances, that very many cases will get to the board," he said. "Three Mercy Hospital employes took their grievances to the employes' committee, but it held off so long before it took any action that the men found jobs some place else.

"Suppose a hospital employe has a grievance and takes it to the hospital grievance committee and is turned down. He then has to take it to the hospital superintendent. If the superintendent turns him down he then has the privilege of going to the board.

"I doubt, however, if any employe would go that far. If he takes his grievance to the board his job will be in jeopardy."

He said he doubted if the existence of the board would mean very much unless employes in the hospital are unionized, and virtually the only union members are hospital maintenance employes in the Electrical Workers Local.

Another union official, who asked that his name not be used, said a worker in one of the hospitals was fired arbitrarily by his supervisor. The employe complained to the hospital's employe council. Once more, weeks went by without any action's being taken.

The employe, a friend of the union official, went to him to see what he could do about getting reinstated. The official then took the case directly to the hospital superintendent. The superintendent promised that the employe would be returned to his job.

Howard H. Rediger, executive secretary of the Toledo Industrial Union Council (C.I.O.), when asked to comment on the board, said he thought "the principle of the thing is good."

"I think the time will come, however, when the present setup will have to be revamped in some way, so more prompt action can be taken when an employe has a grievance," he said.

"If it can prevent serious trouble, that will be all to the good. I don't believe a hospital should be struck. To me, that is a very bad thing."

Asked about Mr. Richards' comment that three Mercy Hospital employes had encountered delay in getting action from the hospital's employes' committee, Sister Mary Blanche, administrator at Mercy, said she had heard nothing about it and was anxious to know what had happened.

She said the employes' committee, set up to handle grievances, is strictly an employe organization with no interference from the hospital administration. It is elected annually by ballot by hospital employes in every department and meets once a month. The hospital personnel director presides.

"Our employes seem very happy and satisfied with the setup," she said. "Anyone with a grievance is encouraged to talk freely." ■

A Lawyer Looks at Hospital-Labor Relations

Robert J. Doolan

1. Hospitals cannot safely rely upon a legal exemption on the basic issue of recognition or nonrecognition of a union because federal jurisdiction is probably not applicable and most states have no legislation at all providing for election procedures. In the dozen or so states having such legislation, only about half have an exemption for charitable, nonprofit organizations. Even in these states there is no exemption for proprietary institutions.

2. There are widespread personnel practices in hospitals that are so substandard by modern standards that the emphasis should be on the improvement of personnel practices to the fullest extent that is financially possible.

3. Institutions should make use of a periodic audit of personnel practices, either on a community basis, an area basis, or on an individual basis. This technic enables a hospital to set forth in writing the answers to many specific questions and in so doing shed light on areas of vulnerability. The answers to these questions should be assessed to determine what constitutes minimum acceptable practice in each area of personnel activity. What is minimum should be measured not only against the possibility of unionization, but also in terms of prevailing practice in the community. To prepare such an audit with guidance statements obviously takes time, but the job can be done within a reasonably short period of time by a competent committee of hospital executives having the advice of a competent personnel and labor relations consultant.

4. In this matter, time is of the essence. Hospitals not now under the gun, as in New York City, should use the here and now to institute a sensible and practical preventive program. ■

Mr. Doolan is a partner in the law firm of Fellner and Rovins, which serves as counsel for several New York hospitals currently involved in labor negotiations. He was formerly personnel director of Allied Stores Corp.

A.M.A. Delegates Approve New Policies on Osteopaths, Closed-Panel Medical Plans

ATLANTIC CITY. — Hospitals required by law to admit osteopaths to practice were taken off the hook here last month when the American Medical Association told the Joint Commission on Accreditation of Hospitals to go ahead and inspect such hospitals, "without prejudice."

Dr. Kenneth Babcock, director of the Joint Commission, estimated there might be as many as 300 hospitals affected, in nine states. Under present commission rules, however, the hospitals will first have to be listed by the American Hospital Association — a requirement for eligibility to be inspected for accreditation.

After thus opening the door a thin crack to osteopaths, the A.M.A. House of Delegates, in its annual session here, quickly slammed it shut again by rejecting a Judicial Council report recommending that doctors of medicine be permitted to teach in osteopathic schools and that doctors of medicine be permitted to "associate professionally" with osteopaths who practice scientifically and have unlimited licenses. Such association with osteopaths has always been considered unethical by the A.M.A.

It still is. As amended following extended discussion, the report said only that doctors of medicine could teach students "in an osteopathic college which is in the process of being converted into an approved medical school under the supervision of the A.M.A. Council on Medical Education and Hospitals." There was only one osteopathic college [Los Angeles] which appeared to qualify.

The report also recommended appointment of a liaison committee of the A.M.A. to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern, including interprofessional relationships on a national level.

In another action that was widely believed to represent substantial relaxation of A.M.A. misgivings about closed-panel prepayment plans, the House of Delegates approved most of the recommendations of the A.M.A. Commission on Medical Care Plans.*

As finally approved by the House of Delegates and thus embodied in A.M.A. doctrine, the commission report included the following recommendations on the subject of free choice of physician:

1. Free choice of physician is an important factor in the provision of good medical care. In order that the principle of free choice of physician be maintained and fully implemented, the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost people can afford.

2. Those who receive medical care benefits as a result of collective bargaining should have widest possible choice from among medical care plans for the provision of such care.

3. The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives.

Approval of these and other commission recommendations came after a lengthy reference committee discussion during which A.M.A. and state and county medical society relations with such prepayment plans as H.I.P. in New York, the United Mine Workers Welfare and Retirement Fund, and the Kaiser Foundation in California were discussed at length. During its studies of the commission report prior to the annual session, the reference committee appointed to consider the report had queried state medical associations on the question of free choice, it was reported. One of the questions was, "Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable and essential to good medical care without qualifications?"

Of 40 state associations replying to the question, only nine answered "Yes," Dr. John S. DeTar of Milan, Mich., chairman of the reference committee, reported. Sixteen associations qualified their answers. "Many associations stated that the principle of free choice is fundamental but that its application is subject to qualification," Dr. DeTar said. Twelve associations answered "No," and three states returned other answers, he said.

The other question directed to state medical associations by the committee was, "What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?"

Eighteen associations indicated that physician participation is acceptable, it was reported, and eight associations submitted qualified answers. Nine states indicated participation is unacceptable, and five associations returned other answers, Dr. DeTar said.

"Your reference committee considers that these disclosures, together with supporting evidence presented in the hearings, warrants the adoption of policy by the association in regard to [closed-panel] plans and physicians associated with them," the report stated. "This is in keeping with the decision of this House of Delegates . . . on the necessity for a reassessment of some of the medical profession's previous policy statements and attitudes toward closed-panel plans."

As has been the case at most A.M.A. sessions in recent years, a resolution was introduced at this session charging the Joint Commission on Accreditation of Hospitals with "bureaucratic dogmatism" and "unrealistic rules and regulations having little relationship to local conditions."

The House of Delegates took no action on the resolution, noting that the Joint Commission has made "excellent progress" and that its problems had been thoroughly reviewed by a special A.M.A. committee in 1956.

A similar resolution charging arbitrary methods of handling internship approvals by the A.M.A. Council on Medical Education and Hospitals was disapproved, on recommendation of a reference committee, when council representatives demonstrated that the council does have a satisfactory method for notifying hospitals of deficiencies and does allow adequate opportunity for correction of deficiencies before an internship program is deleted from the list of approved internships.

(*See also story on Page* 132)

*A.M.A. Study Finds Health Insurance Plans Gaining. Mod. Hosp. 91:6 (December) 1958.

Modern Hospital of the Month

Quakeproofing Puts Plan on a Solid Footing

Douglas D. Stone

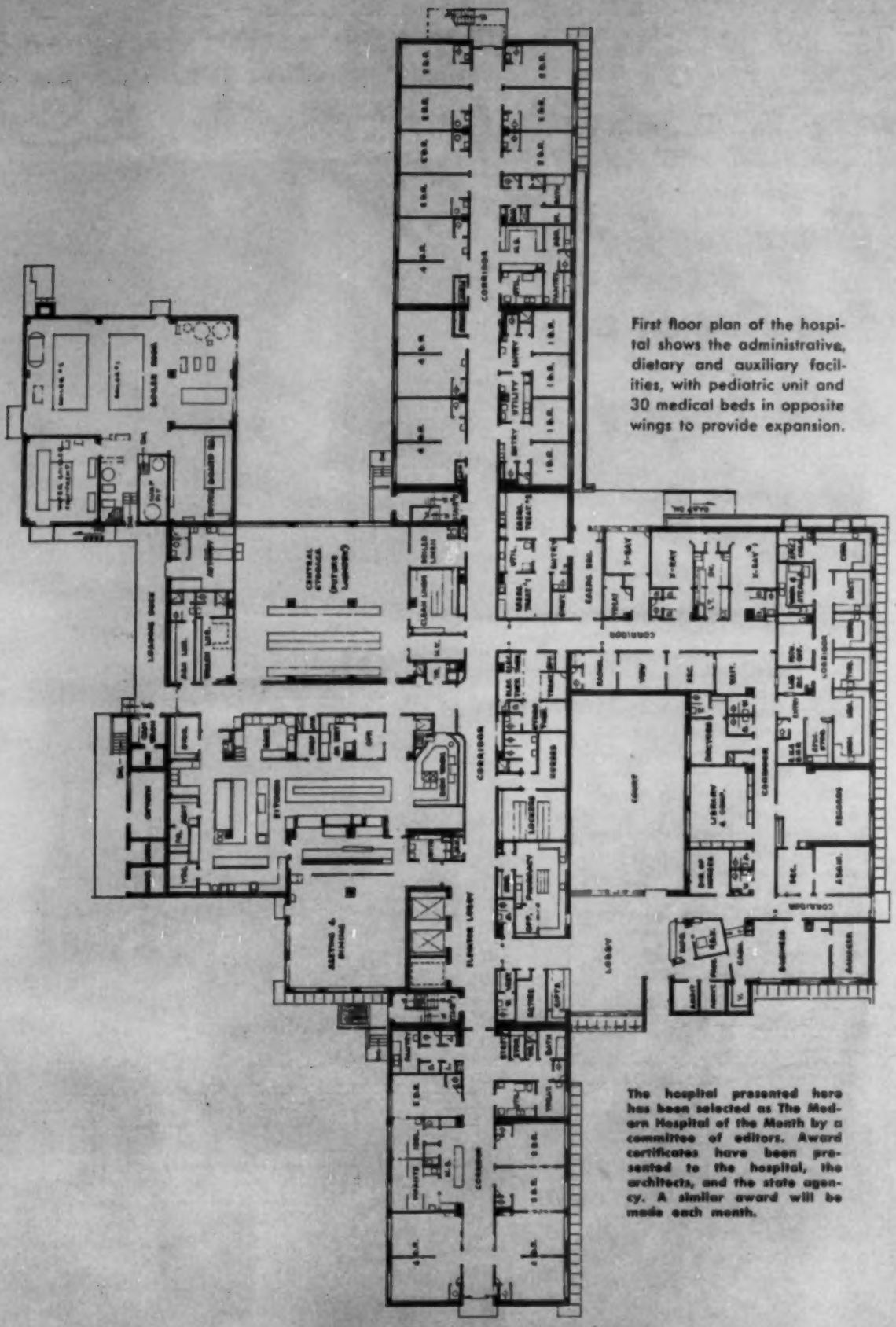
TWO major guideposts marked our course in designing the Greater Bakersfield Memorial Hospital. One was functional: the need for a compact, efficient, self-contained hospital to meet current needs but with the planning for economical expansion explicitly incorporated in the design. The other was physical: unfavorable soil conditions and difficult climate.

The building site was overlaid by a deep layer of fine, sandy soil that ruled out a basement excavation and forced the basic physical services onto one floor. The final solution to the soil problem was a foundation that combined continuous wall footings and isolated spread footings at the interior columns, built in an engineer-controlled, highly compacted backfill. On this foundation the reinforced concrete building was erected.

(*Continued on Page* 82)

Mr. Stone is an architect of the firm of Stone, Mullov, Marraccini and Patterson, San Francisco. Participating with the architects in the construction of the hospital were: Wright, Metcalf and Parsons, resident architects, Bakersfield, Calif.; August Koenig, hospital consultant; Washington and Mitchell, San Francisco, structural engineers; Buonaccorsi, Murray and Lewis, San Francisco, mechanical and electrical engineers; Guy E. Hall, general contractor.

Exterior of Greater Bakersfield Memorial Hospital.



First floor plan of the hospital shows the administrative, dietary and auxiliary facilities, with pediatric unit and 30 medical beds in opposite wings to provide expansion.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and the state agency. A similar award will be made each month.

Left: All two and four bed wards have this unusual staggered bed arrangement that permits the nurse to view two sets of patients at the same time. A suite of four-bed rooms has been provided to serve for all-purpose use.

DESIGN OF FIRST FLOOR CONTROLS INTERNAL TRAFFIC

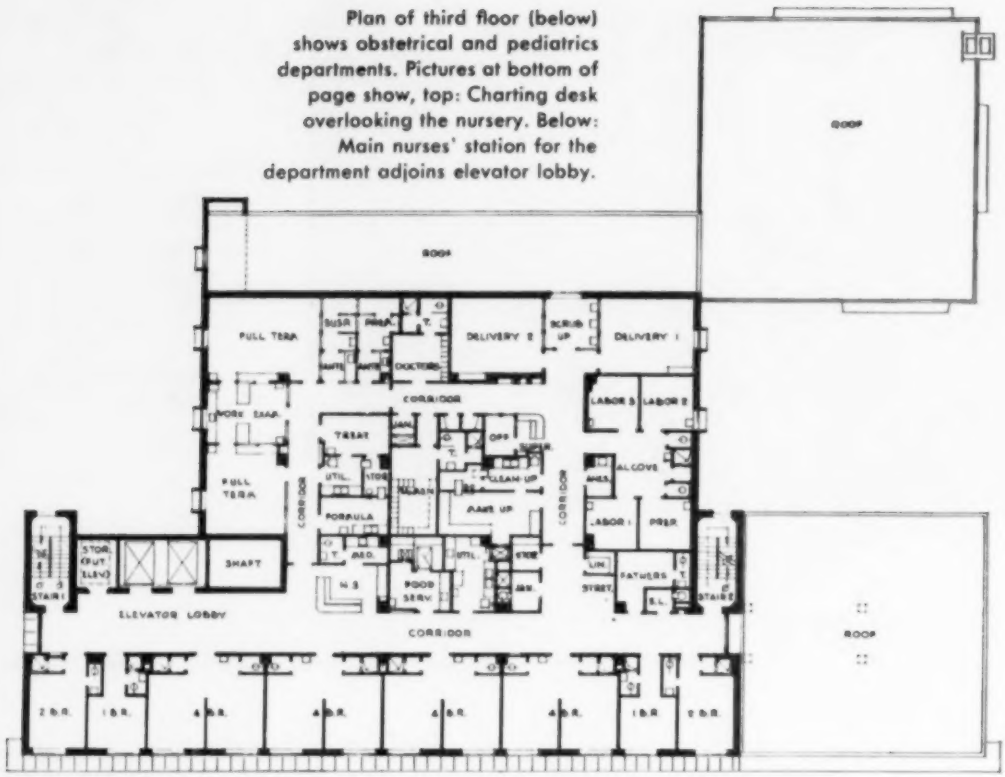
OUTLINE OF CONSTRUCTION COSTS

Total project cost	$2,501,927.46
No. of beds	106
(Planned for 80 additional)	
Cost per bed	23,615.00
Total square feet	65,037
Square feet per bed	614
Cost per square foot	38.47
Total cubic feet	792,668
Cubic feet per bed	7,478
Cost per cubic foot	3.15

Above: view of the pharmacy on the first floor shows portion of pharmacist's office.

View of central supply department located on the second floor within the operating room suite.

Plan of third floor (below) shows obstetrical and pediatrics departments. Pictures at bottom of page show, top: Charting desk overlooking the nursery. Below: Main nurses' station for the department adjoins elevator lobby.



(*Continued From Page* 79)

The hot dry climate itself imposed requirements on the design. Complete air conditioning throughout was required and this, in turn, required as much freedom as possible for mechanical systems without excessive story heights. The solution was found in a series of one-way slabs supported by wide, shallow beams which opened the way for the air conditioning ducts.

A second concession to the climate are the louvers that grace the windows facing south. The louvers, we think, add not only a distinctive note to the exterior design but are, in the administrator's words, "a tremendous aid to patient comfort and medical control of light."

Quakeproofing the structure came in for special attention, since Bakersfield was severely shaken as recently as 1952. Lateral requirements were met with reinforced concrete sheer walls. Wall openings were reinforced with either specially designed or normal periphery steel, and corners were braced by diagonal bars in the structural slabs.

Finally, in anticipation of future expansion, reinforcing steel and vertical columns as well as slabs and beams were finished in a way that will permit quick and simple extension of the building both vertically and horizontally.

The administrative services, as well as the centralized dietary service, are located on the first floor, along with the emergency, x-ray, laboratory and physical therapy facilities. The first floor also holds the pediatrics unit, conveniently located on the west end of the building for eventual expansion, and 30 medical beds on the opposite wing.

The boiler system is housed in a wing that flanks the rear end of the building so it can be expanded. The heating system is forced circulation hot and chilled water combined on all circuits to rooms, zoned by floor and exposure.

The boiler system is housed in a wing that flanks the rear of the building so it, too, can be extended. The same wing houses the water chiller equipment. Natural gas is used in the boilers, with fuel oil standby and a diesel motor generator set to take over in event of a power failure. The standby system serves the key areas – surgery, delivery, nursery, minimum requirements for corridor lights, boiler room, fire alarm, and doctors' call.

The heating system is forced circulation hot and chilled water combined on all circuits to individual room units, all zoned by floors and exposure. Three separate systems provide the conditioned air to the various sections in accordance with their individual requirements. Three hot water systems are provided: for patients, the kitchen (these are cross-connected), and for the laundry when it is built.

The second floor holds the major surgeries with their necessary ancillary rooms, facilities and surgical beds. It, too, is laid out with the future in mind, for expansion is possible in three directions. The obstetrical unit located on the third floor is also designed for the addition of beds and facilities, if needed, on three sides.

Finally, in terms of the future, the vertical elements were finished in such a way as to make the addition of a fourth floor relatively economical and efficient.

In all, the hospital provides 65,037 square feet of floor area – an average of 614 square feet per bed. In addition, generous parking areas are provided on the grounds – and a carefully marked heliport. Total project cost was $2,501,-927 – an average of $23,613 per bed. ■

FOUR-BED ROOMS GIVE SEMIPRIVATE EFFECT

W. Kevin Hegarty

THE Greater Bakersfield Memorial Hospital is modern in every respect, but if I had to pick out three outstanding features of the hospital and its design they would be as follows:

1. The entire third floor of the hospital is devoted to the maternity department. It is the most workable unit of its kind that I have had the pleasure of being associated with. Its design facilitates the admission of the patients, their care, and the flow of work all over the maternity department. This observation is concurred with wholeheartedly by the whole obstetrical staff.

2. The largest patient room in the hospital accommodates four beds. The beds are placed two on each side of an interior wall partition. This, in effect, gives semiprivacy in four-bed accommodations; it has proved very satisfactory because it means that the efficiency of the four-bed hospital room can be achieved and yet semiprivacy can be enjoyed by the patients.

3. The interior exposed patio adjoining the lobby of the hospital is a beautifully landscaped view which greets the patients, visitors and all of the public as they enter the front door of the hospital. The patio shrubbery blends well with the community and the modern approach of the design of the hospital. ■

Mr. Hegarty is administrator of Greater Bakersfield Memorial Hospital, Bakersfield, Calif.

ABOUT PEOPLE

Administrators

Dr. Vane M. Hoge, who became executive director of Hospital Planning Council for Metropolitan Chicago when he retired from the U. S. Public Health Service a few years ago, has returned to Washington as assistant director of the Washington service bureau of the American Hospital Association. He has been succeeded on the hospital planning council by **Dr. Karl S. Klicka,** former director of Presbyterian-St. Luke's Hospital, Chicago. Dr. Hoge, a graduate of Jefferson Medical College, Philadelphia, entered the Public Health Service as an intern in 1928. Later he completed the course in hospital administration at the University of Chicago and then served as a hospital consultant for P.H.S. He organized the P.H.S. Hospital Facilities Section in 1940. Dr. Klicka is a graduate of Allegheny College and Western Reserve University. He received a master's degree in hospital administration from the University of Chicago. Dr. Klicka served as director of St. Barnabas Hospital, Minneapolis, before taking the Presbyterian Hospital appointment, and had served as director of Women's Hospital, New York City, for five years and as assistant director of Grasslands Hospital, Valhalla, N. Y. He is a fellow of the American College of Hospital Administrators, a member of the executive committee of the health division of the Chicago Welfare Council, president of the Chicago Hospital Council, and a member of the board of trustees of the Illinois Hospital Association.


Dr. K. S. Klicka

Richard E. Sawyer has been appointed administrator of Frankford Hospital, Philadelphia. He is a graduate of the school of public health, Columbia University, and was for several years assistant administrator and instructor in hospital administration at American University Hospital, Beirut, Lebanon.

Walter M. Oliver has been appointed administrator of Long Beach Community Hospital, Long Beach, Calif., to fill the vacancy caused by the death of **Howard B. Hatfield.** Mr. Oliver had served as business manager and administrator of Children's Hospital, San Francisco. He has been president of the Central Coast Hospital Conference, president of San Francisco Hospital Conference, vice president of Hospital Service of California, treasurer and member of the board of trustees of the California Hospital Association, and treasurer of the Association of Western Hospitals.

Manley C. Solheim has been appointed administrator of Jeanes Hospital, Philadelphia, succeeding **F. William Burg Jr.,** who died last January. **Frances Dixon,** director of nursing, had been serving as acting administrator. Mr. Solheim had served as administrator of Tioga County General Hospital, Waverly, N. Y., for the last seven years. Formerly he was assistant superintendent of Binghamton City Hospital, Binghamton, N. Y. Mr. Solheim has a degree in hospital administration from Northwestern University and is a member of the American College of Hospital Administrators.


M. C. Solheim

Paul S. Jarett has been appointed administrator of Burbank Hospital, Burbank, Calif. Formerly administrator of West Valley Community Hospital, Encino, Calif., Mr. Jarett has also served as assistant administrator of City of Hope Medical Center, Duarte, Calif., and Mt. Sinai Hospital, Minneapolis. He has a master's degree in hospital administration from the State University of Iowa and is a member of the American College of Hospital Administrators.


P. S. Jarett

John D. Rollins has resigned as administrator of Ontonagon Memorial Hospital, Ontonagon, Mich., to accept an appointment by the United Presbyterian Church, U.S.A., as administrator of two 100 bed missionary hospitals in Amballa and Ludhiana, India.

James E. McNelley has been appointed administrator of Memorial Hospital, Glendale, Calif. He was formerly administrator of Beverly Community Hospital, Montebello, Calif., and prior to that was assistant administrator of Elkhart General Hospital, Elkhart, Ind. He succeeds **B. J. Caldwell,** whose new appointment was announced in The Modern Hospital in March.


J. E. McNelley

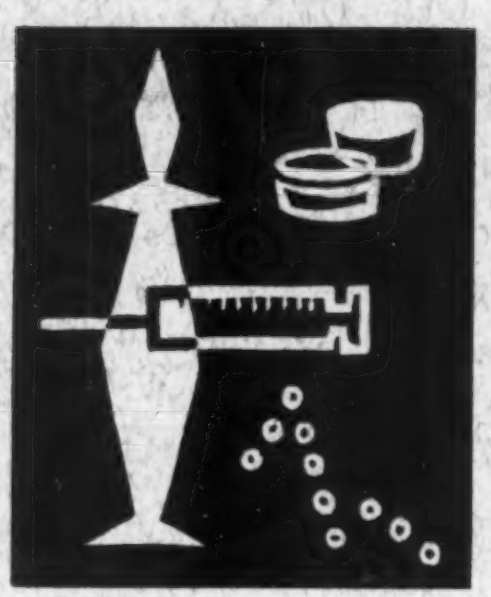
Lester L. Lamb has been named administrator of Marmet Hospital, Marmet, W. Va. He had been administrator of Hampshire Memorial Hospital, Romney, W. Va., since receiving his master's degree in hospital administration from Medical College of Virginia in June.


L. L. Lamb

William E. Worcester Jr. has been appointed hospital administration adviser with the International Cooperation Administration's Mission to the Philippines. He was formerly administrator of Valley Hospital, Ridgewood, N.J., and assistant director of New England Deaconess Hospital, Boston, and Memorial Hospital, Worcester, Mass. Mr. Worcester is a graduate of the University of Vermont and has a master's degree in hospital administration from Columbia University. He is a member of the American College of Hospital Administrators.

Edwin B. Bolz has been named associate administrator of Benedictine Hospital, Kingston, N.Y. He had been assistant administrator of Staten Island Hospital, Staten Island, N. Y., for the last four years.

(*Continued on Page* 168)



Drug Therapy

in the Modern Hospital

The "revolutionary advances" in modern medicine have brought in their wake another revolution — in the area of drug therapy. This revolution has not been so widely discussed but is of great importance to hospitals, as is the emergence of the pharmacist as an equal partner with other professional staff members in the care of patients. Both of these aspects of hospital pharmacy are examined on the following pages by leaders from the fields of medicine, nursing, pharmacy and from the drug industry.

How To Promote

Sarah H. Knutti, M.D.

We have reached an era full of complicated drugs and new toxicity problems

TWENTY years ago most hospital pharmacies were relatively small and individual prescription compounding was common. Hospital drug formularies were still much what the name implies, containing a goodly compilation of favorite formulas, personalized by the name of their author, or dubbed "Bladder Mixture," or "Tablet 52" — the latter a not too safe practice! The now little used apothecary system of measures was still widespread. Preparations of morphine, phenobarbital, aspirin, digitalis, adrenalin, ephedrine, the arsenicals for syphilis, anti-sera against pneumococci and tetanus, typhoid and anti-smallpox vaccine, ether and iodine went far toward encompassing a doctor's armamentarium of materia medica.

From this era, in which the number of really essential and useful drugs could almost be counted on the physician's fingers and toes, we have arrived, in jet-propelled time it seems, to an era in which keeping up with even the names of new drugs is a major problem. Concurrent developments in chemistry generally, in the development of a host of new substances such as new detergents, new plastics, new radioactive substances, the new war-gas-related insecticides, and the discovery of many side effects to a large portion of the new drugs which are continually being introduced, have also added new toxicity problems.

Lucy Kramer, research analyst in the United States Public Health Service, has, in scholarly and also telling fashion, described[1] the changes in drugs and medicines in use, in numbers, type, form and cost, in recent years. Among other matters her paper depicts the great changes which have taken place in the origin of basic drugs included in the National Formulary over the years. Botanicals have dropped sharply and steadily, from 80 per cent of N.F. basic drugs in 1916 to only 30 per cent in 1955, while organic chemical substances rose from 10 per cent in 1926 to 60 per cent in 1955. She further notes that many 1958 prescriptions could not have been written 20 years previously since many of the drugs now used were then unknown, such as penicillin, first introduced in 1940, streptomycin (1946), antihistamines (1947), corticosteroids (1950-51), chlortetracycline (1950), and rawolfia and meprobamate (1953). Don Francke notes[2] that a 1954 study revealed more than 3300 new drugs and dosage forms marketed in the seven years ending with 1954, and the *New England Journal of Medicine* in an editorial, "The Mails Go Through!"[3] recounts the 1957-58 study of a year's mail of a busy general practitioner in which he received 4901 pieces of mail detailing 715 drug products, 198 of which were new.

Even the *Exchange*, the little monthly periodical pub-

[1]For this and succeeding bibliographic references, please turn to page 108.

and Assure Rational Drug Therapy

lished by the New York Stock Exchange for the information of investors, has taken cognizance of recent drug developments. In the April 1959[4] issue it notes that the combined expenditures for research of 12 reporting drug companies increased from $24.6 million in 1948 to $82.2 million in 1958.

In the face of such mushrooming developments, how is good drug therapy maintained and promoted?

A primary prerequisite is, of course, good pharmacy service, headed by a well trained pharmacist alert to new developments. He needs a modern pharmacy, equipped to take advantage of the not-so-minor industrial revolution concomitantly occurring in hospital pharmacy practice today (in hospitals that are large enough, prepackaging, bulk compounding, manufacture of injectables, all in carefully controlled precision, have largely replaced individual time consuming prescription compounding). In small hospitals such pharmacy service may be provided through extension of the services of a local retail pharmacist, part time.[5]

Whatever the method of providing such pharmacy service, it should meet accepted standards. Among measures of this are the standards of the Joint Commission on Accreditation of Hospitals, set forth in the Standards themselves, amplified and interpreted in other J.C.A.H. publications such as the commission's *Bulletin*, its director's column in hospital periodicals, and "Hospital Accreditation References."[6] The "Minimum Standard for Pharmacies in Hospitals," developed, and revised by the division of hospital pharmacy of the American Pharmaceutical Association and the American Society of Hospital Pharmacists, from the 1935 standard prepared by Spease and Porter, has also been recognized by hospitals, physicians and pharmacists as a valuable and concise document of basic considerations. It and considerations for future progressive revision are set forth by Paul Parker in the *American Journal of Hospital Pharmacy*.[7]

Given such good pharmacy service, the major role in good drug therapy is played by the individual physician who must keep up-to-date by reading the many excellent current articles and drug therapy reviews such as those published in the *New England Journal of Medicine* in the series "Current Concepts in Therapy," in attending meetings where drug therapy is discussed, and in collaring his colleagues himself in formal or informal discussions. He uses the current edition of "New and Non-Official Drugs,"[8] an annual publication, which is in effect a living monument to the efforts of the American Medical Association's Council on Drugs on behalf of sound and up-to-date drug therapy. (This Council since 1905, under its present name and its former name of the Council on Pharmacy and Chemistry, has continually evaluated new drugs and reported on them to the profession, through the N.N.D. and its predecessor, "New and Non-Official Remedies," and through the *J.A.M.A.*). He may consult a new newsletter on drugs and therapeutics,[9] whose advisory and editorial boards include faculty members from Yale, Columbia, Johns Hopkins, Buffalo, Utah and Jefferson Schools of Medicine.

In many hospitals now he probably also consults the American Hospital Formulary Service, a new loose-leaf publication of the American Society of Hospital Pharmacists[9] which had it origin in a proposal and basic work by Don E. Francke, director of pharmacy service, University Hospital, Ann Arbor, Mich. (It is a collection of drug monographs, with a subscription service to keep it up to date as new drugs gain recognition. A unique provision is the inclusion at the end of each monograph for an entry by the individual hospital noting whether the particular drug or drug form described has been selected for the hospital's own formulary. Thus the A.H.F. can serve not only as the hospital's own formulary showing drugs and dosage forms routinely stocked, but also as a reference to many additional preparations about which concise information is desired.)

He also is alert to observe for himself the actions and side effects of the drugs he uses.

Today, however, even with these aids few practicing physicians can read enough, see enough, discuss enough to keep up. The nurses on whom the physician depends for the carrying out of his drug therapy orders and whom he also expects to observe their effects, and to observe and promptly report adverse reactions, have almost more of a problem. Most of them are responsible for the patients of not one but several physicians, each of whom may emphasize a different group of drugs. The pharmacist must meet drug needs and yet keep a manageable inventory.

Much coordination and teamwork stem from the day-to-day working relationships of these people and their common desire to serve their patients well. However, most doctors and hospitals today have found that the pharmacy committee is an indispensable adjunct to good drug therapy. This committee cannot accomplish the teamwork mentioned, but it can do much to set the stage and to advise in providing the props. Basically it provides a means of taking advantage of the pooled opinion of experts.

Such advisory committees first came into being, for obvious reasons, in larger hospitals, and were originally composed primarily of physicians, meeting with the pharmacist and administrator to recommend "standards as to

Sarah H. Knutti, M.D., associate clinical director of Miners Memorial Hospital Association, was, before her marriage in the summer of 1957, Dr. Sarah H. Harwicke and secretary of the Council on Professional Practice of the American Hospital Association. Dr. Knutti is a graduate of Vassar College and Johns Hopkins University. Following internship and residency at Strong Memorial Hospital, Rochester, N.Y., she was a member of the pediatric faculty at the University of Rochester and Cornell University. She was for several years assistant director of Strong Memorial Hospital and assistant professor of hospital administration at the University of Rochester.

Greater need than ever

the types of preparations, sera, vaccines, mouth washes, etc., to be used on the wards of the hospital."[2] The development of hospital formularies was a major function of such committees in the Thirties and the rules for the establishment and use of formularies and for admission of new drugs demonstrate that in such centers as New York Hospital-Cornell University development of "a system of rational therapeutics"[3] was well established. However, such was not the case in the majority of small institutions and it is only recently that both the value of pharmacy and therapeutics committees in smaller hospitals and the potential of a broader scope for the committee than the hospital formulary have been realized. The Joint Commission on Accreditation of Hospitals recommends such committees for all hospitals. A recently prepared statement of the joint committee of the American Hospital Association and American Society of Hospital Pharmacists on the pharmacy and therapeutics committee has been approved by the parent organizations and published,[4] and is well worth consulting.

The pharmacy and therapeutics committee today usually brings together at least a physician representing each of the major services of medicine, obstetrics-gynecology, pediatrics and surgery, the administrator, and the pharmacist, who acts as secretary, to bring an orderly approach to drug therapy problems. More and more, however, other important persons, especially a nurse, are being included on the committees.

The Henry Ford Hospital, a sizable institution of 850 inpatient beds and about 2000 outpatient visits per day, has an active pharmacy committee of 18 which includes two nurses, an anesthesiologist, a physiologist, and a pharmacologist-toxicologist. The indispensable member, however, is likely to be the pharmacist, as a committee faced with meeting without him is likely to discover.

What does the committee do? According to the J.C.A.H. and the joint committee statement referred to, its work should encompass advice to the medical staff and hospital pharmacist on development of a formulary or drug list, and subsequent periodic review of it and periodic evaluation of data concerning new drugs or preparations in order to recommend deletions and additions to keep the list or formulary up to date; recommendations concerning drugs to be stocked in nursing units, outpatient and other patient service units within the hospital; prevention of unnecessary duplication in the same basic drug or its combinations, establishment or planning of educational programs for the professional staff, on drugs and their use; recommendation of policies regarding the safe use of drugs; studies of problems involved in distribution, labeling and administration of drugs for inpatients and outpatients; studies of adverse reactions to drugs; periodic evaluation of medical records in terms of drug therapy. This is a rather comprehensive list-

for the collection of data on adverse drug reactions

ing, to which, however, might be added one other important matter, the promotion of organized efforts within the hospital in treatment of accidental (or intentional) poisoning.

The references cited give further details on how the committee works and aids to its work and recommended procedures. Meetings at regular intervals, announced well in advance, facilitate consideration of requests for additions to the formulary and other business.

A few matters are worth special mention, however. The safe use of drugs today is far more of a problem than it used to be even a few years ago. Many new drugs are not only potent therapeutically but capable of doing great harm in over-dosage or if too long continued or through unforeseeable but dangerous individual idiosyncracy. Often new drugs, extensively tested, are used rather freely for some time before untoward effects are appreciated. (A good example is meperidine, once thought nonhabit forming.) Not only do we have these problems with drugs which have been clinically investigated and released by the Federal Food and Drug Administration for general use, but also, obviously, the increased production of new drugs means that more must be clinically tested, somewhere, and on someone.

Clinical investigation of new drugs is an important and necessary endeavor but one which carries with it responsibilities not to be taken lightly. Appropriately an excellent review of guiding principles in this field comes from the National Institutes of Health, where much clinical investigation is undertaken. It is part of a 1958 symposium on the subject[7] which should be reviewed by every pharmacy and therapeutics committee in whose hospital any clinical investigation of drugs is carried out. Good clinical investigation is to be encouraged but "desk drawer research" by persons not fully qualified to do it is not, as Dr. Ponka of the Henry Ford Hospital emphasizes. Pharmacy and therapeutics committees should see to it that clinical investigation of drugs is carried out according to rules that will safeguard the patient and all concerned. Pharmacy and therapeutics committees also should see to it that when information of unexpected untoward effects of released new drugs appears, the medical staff is promptly put on the alert.

Further, there is need more than ever today for the collection of accurate data on adverse reactions to drugs. The Food and Drug Administration, in cooperation with the American Association of Medical Record Librarians, the American Society of Hospital Pharmacists, and the American Medical Association in 1955 began a pilot study with a small number of hospitals, both voluntary nonprofit and governmental, providing report forms and tabulating results. A report on this work was given at the Tri-State Hospital Assembly last April at the meeting of hospital pharmacists.[8]

The Food and Drug Administration is interested in seeing this work expand because of the obvious benefits to patient care of obtaining prompt and complete information on the extent and severity of such reactions. Forms which other hospitals can use for the purpose of collecting their own data or reporting to it are in process of revision by the Food and Drug Administration, and a guide for their use and further details are obtainable from it.[9] The identity of patients is not revealed in these studies and names need not be reported to the Food and Drug Administration.

Prevention of accidental poisoning and prompt and adequate therapy when it still occurs have for some time been recognized as nationwide problems of importance. They are also problems in which hospitals and their pharmacy and therapeutics committees can help greatly. Since the establishment, in 1953 in Chicago, of the first poison control center under the sponsorship of the Illinois chapter of the American Academy of Pediatrics, about 280 such centers equipped to furnish prompt information to physicians and others have been established, most of them in hospitals. These centers furnish first-aid information to lay persons, advising them to call a physician, and are equipped to provide more detail on identity and toxicity of a multitude of products and on current methods of treatment to physicians. Their work in this and follow-up studies and a review of the current status of poison control (including the status of new antidotes) was the subject of an excellent report last October, from the National Clearinghouse for Poison Control Centers, Accident Prevention Program, Public Health Service, in Washington, D.C.[10] A symposium on poisoning containing much basic material, which should be reviewed by every pharmacy and therapeutics committee, was published[11] in 1958.

One thoughtful physician and teacher notes the large portion of accidental poisonings due to drugs and observes that delays in identifying the substance and amount consumed can jeopardize recovery. He suggests that all medications given patients to take home should be labeled with the name of the drug and strength of preparation. This practice appears to be increasing, outside as well as in the hospital. Pharmacy and therapeutics committees might well consider recommending it as a routine hospital practice. (Obviously, provision should be made for exceptions where there is special reason for a patient not to be told what he is taking.) Such routine identifying labeling of medications could save lives.

The majority of hospitals are probably not equipped to become information dispensing centers, which, to function properly, should be manned on a 24 hour telephone basis. All hospitals can and should prepare to provide treatment facilities, usually under the general supervision of one physician who is particularly interested in the problem.

(*Continued on Page* 108)

Kenneth B. Babcock, M.D.

Rx for Accreditation: Keep Drug

IN THIS age of chemotherapy it is only to be expected that the hospital pharmacy should move into a position of equality with other departments. Thanks to the rapid developments in the drug industry, the pharmacist has switched roles – from humble apothecary to the modern "Sorcerer's Apprentice," if not the Sorcerer himself.

In keeping with the emergence of the pharmacy as an essential department, the commissioners of the Joint Commission on Accreditation of Hospitals are urging the formation of a strong hospital pharmacy and therapeutics committee that meets at least twice yearly. Although it is not a requirement, the Joint Commission considers this committee an important aid to the improvement of patient care in hospitals.

This committee assists in the formulation of broad professional policies regarding the evaluation, selection, procurement, distribution, use, safety procedures and other matters relating to drugs in hospitals. It serves as the organizational line of communication or liaison between the medical staff and the pharmacy department. In conjunction with the staff program committee, this committee can be of inestimable value as an educational tool. Whether staff meetings are held monthly or quarterly is of little importance. A good hospital committee with an eye to making staff meetings interesting can stimulate the right person or persons on the staff into giving a 15 to 20 minute presentation on drugs and drug therapy that will redound to the hospital's credit.

A surveyor recently reported on one hospital he visited where this is being done. At each meeting 15 minutes were devoted to a talk on therapeutics with total discussion limited to 10 minutes. The speaker synopsized his talk prior to the meeting on two mimeographed sheets of paper and distributed them to the staff. The medical staff members stated they used them in their practice as therapeutic guides. Among the topics noted by categories were: "common drugs and their office usage in ophthalmology and otolaryngology"; "the use and abuse of antibiotics"; "what the average practitioner should know about anticoagulants"; "the true value of vitamin preparations."

On the two mimeographed sheets the speaker had the drug category listed with the names, purpose, function, side effects, contraindications, and so forth of each drug. In the last paragraph he usually made his own suggestions and recommendations as to the drugs of choice. As can be seen, this hospital had energy and imagination and was out to improve the quality of care given to patients and at the same time help in the education of its doctors.

Many hospital administrators do not realize that they must help in the functioning of a good pharmacy and therapeutics committee and do everything in their power to stimulate the committee into action. The negative and defeatist attitude is easily seen by the frequent letters that read: "Why do we have to have such a committee?" "My committee met and couldn't find anything wrong in the pharmacy and voted not to meet again unless an emergency arose." "Can you suggest a possible agenda?" This last question is so common that a list of possible subjects for study and review by the pharmacy and therapeutics committee is included on page 104.

Job for a Committee

The Joint Commission has recommended that every hospital should "develop a formulary or drug list of accepted drugs for use in the hospital." This is not an easy task. Before a committee tackles a formulary, the pharmacist and administrator should help prepare the way by having current articles on formularies available. If possible, sample formularies from other hospitals should be available for study and review, especially from hospitals of comparable size and type. Before going into the writing of a formulary the committee should ask itself a few philosophical questions:

1. What is our over-all picture and need?
2. Just who is this formulary written for and who is going to use it and should use it, *i.e.* medical staff, house officers, nurses?
3. Why can't we use an already prepared and acceptable formulary such as the American Hospital Formulary Service?
4. When acceptable and published how often will it be necessary to revise it and keep it up to date?
5. At what staff meetings can an opportunity be given

Standards High

to present it to the staff and nurses, and explain its purpose and proper usage?

6. Can we get the staff to really prescribe by generic system and also use only the metric system in their prescriptions?

It has been stated that a current hospital formulary in truth is a "local up-to-the-minute United States Pharmacopoeia, if you will, of drugs available to the staff through the hospital's pharmaceutical service." A good hospital formulary is highly recommended for hospital usage. Its preparation is long, arduous and of necessity continuous.

Misunderstood Requirement

The requirement of an automatic stop-order on dangerous drugs is misunderstood frequently by hospitals and physicians. (For discussion of this subject see box.) The Joint Commission on Accreditation of Hospitals has no right to tell physicians what kind and how much medicine they should give to their patients, and does not do so. The commission does desire that drugs, especially dangerous drugs, be given properly with reasonable medical staff controls. The commission is asking that hospital medical staffs establish a written policy that all dangerous medications, not specifically prescribed as to time and number of doses, be automatically stopped after a reasonable time limit set by the staff. It is a protection against indiscriminate, indefinite prescribing of an open-ended type which can result in harm to the patient, physician or hospital. It especially includes such orders as p.r.n., "as necessary," and so on. The following classifications are ordinarily thought of as dangerous drugs: narcotics, sedatives, anticoagulants and antibiotics.

A recent editorial in a Western medical journal called this requirement of the Joint Commission an invasion of physicians' rights and patient-physician relationship. Nothing could be more farfetched and wrong than such a statement. A hospital medical staff should be self-regulatory and write its own rules for the good of the patient and its own protection. No ax falls when the time limit set by the staff expires. The nursing staff merely calls it to the attention of the attending physician at his next visit, saying that because this was an open-ended order (for the

Stop-Orders Stop Doses Safely

Robert S. Myers, M.D.

THE automatic stop-order on dangerous drugs is intended to prevent the prolonged and unsupervised administration of drugs which may be harmful to the patient. As Dr. Babcock points out in the accompanying article, any drug may harm the patient, if it is given in excessive doses for a sufficient length of time, but the following are commonly thought of as dangerous drugs: narcotics, sedatives, antibiotics and anticoagulants. The reasons for this are that individually they are likely to cause addiction, habituation, sensitization or toxic manifestations; they are also among the drugs most commonly prescribed for hospital patients.

It is surprising how often drugs given by p.r.n. orders, and without a specified time limit, are continued beyond the necessity for their use. In an inspection of 100 hospitals in a single state in 1952, I found that the prolonged and unsupervised administration of dangerous drugs was one of the commonest deficiencies encountered in hospitals. Further investigation indicated that this was probably due to the lack of realization by physicians that the patient was still receiving the medication. Medications given are usually recorded in the nurses' notes and the continued use of drugs is not readily noticed from these notes by the busy physician in the course of his daily rounds.

The Joint Commission on Accreditation of Hospitals should not be accused of interfering with the physician's right to prescribe for his patients as he deems necessary. Actually, the commission has never attempted to tell physicians what kind and how much medicine they should prescribe. All the commission requires is that the medical staff of the hospital establish a written policy that all dangerous drugs, not specifically prescribed as to number of doses or the limit of time to be given, be stopped automatically by the nursing staff after a reasonable time limit set by the medical staff. The medical staff should also specify the drugs to be designated as dangerous. In the well organized hospital, the nursing staff will call the physician's attention to the fact that medication has automatically been stopped in the event he wishes the medication to be continued.

Actually, the automatic stop-order has been used for many years for the control of narcotic administration by numerous well organized hospitals. It was also one of the requirements recommended to hospitals as early as 1952 by the American College of Surgeons when it conducted the Program of Standardization of Hospitals. The automatic stop-order has demonstrated its value in protecting the welfare and safety of the patient.

Dr. Myers is associate director, American College of Surgeons, Chicago.

good of the patient and his own protection) would he please renew the order, modify it, or cancel it.

A clinching argument for this staff ruling can easily be pointed out by citing the published bad examples of a hand amputation caused by ergot's being given q/4 hours until gangrene set in, and a death by hemocardia owing to Dicumarol being given q/8 hours with no time limit. Blue Cross and insurance companies both have conducted studies showing excessive costs of hundreds of thousands of dollars to patients because of open-ended forgotten antibiotic orders. Last but not least, it is a federal regulation that narcotics not ordered by specific dosage and time cannot be given for more than 72 hours.

A doctor is a busy man. A drug order, among many, that has been relegated to a buried page or forgotten by him should be called to his attention.

Many hospitals write the Joint Commission concerning the use in hospitals of so-called experimental or new investigational drugs. The latter term is much preferred. In that hospitals are the primary centers for clinical investigations on new drugs it is both wise and right that they be concerned about their proper handling and usage. Not all hospitals have the staff or means to utilize investigational drugs properly. When they are used or their use is contemplated, certain controls, disciplines and educational procedures should be closely followed. As a general rule, investigational drugs should be in the hands of a designated person or committee, with appropriate patient safeguards.

It is preferable that the patient be advised that these drugs are to be used and his consent obtained. Any hospital personnel engaged in giving of these drugs should be educated as to what to expect and what to do if any untoward symptoms or signs develop. The dispensing and handling of these drugs should preferably be from the pharmacy under the supervision of the pharmacist and the pharmacy committee, in order that no slip-ups occur.

A good hospital pharmacy and therapeutic committee can do much to save hospital costs, educate doctors and nurses, and actually improve the quality of hospital care. ■

Kenneth B. Babcock, M.D., is director of the Joint Commission on Accreditation of Hospitals. From 1947 to 1954 he was director of Grace Hospital, Detroit, where he had previously been assistant director and medical director. He had been associated with the hospital from 1926 to 1942 when he entered the army. While in Michigan he served as president of Michigan Hospital Service, Michigan Hospital Association and on the board of directors of the Michigan Medical Service. Dr. Babcock is a fellow of the American College of Hospital Administrators and of the American College of Surgeons. He is a member of the executive committee of the American Hospital Association Blue Cross Commission.

What Is a "New" Drug?

Simply stated, a drug is "new" if qualified experts do not recognize it as safe when used as directed. A new drug remains "new" for a new manufacturer, even though other manufacturers have provided adequate evidence of safety. Each manufacturer must provide adequate evidence for his own product before he can legally market a new drug.

Food and Drug regulations point out that a product may be considered "new" not only when it contains a new active ingredient but also when it includes a new excipient, coating, solvent, carrier or other component. A new combination of two or more old drugs, or a change in the usual proportions of the ingredients in an old combination, may cause the product to be considered a new drug if a question of its safety is introduced. A new use, a new dosage schedule, or a new route of administration for a commonly recognized drug may also result in a new drug within the meaning of the definition. ■

How Rational Drug Therapy Affects Nursing Duties

Margene O. Faddis

ACCURACY of administration of drugs has traditionally been one measure of fitness for the practice of nursing. In the not-very-distant past a sizable number of student nurses have been suspended or expelled from schools of nursing because of a "mistake in medication."

Even in schools where this practice has long since ceased to exist, a considerable amount of apprehension and anxiety is likely to be present when the student is given responsibility for administering drugs. Some teachers who have had long experience in working with staff and student nurses believe there is evidence that many mistakes are made that never become known to anyone, including the nurses who make them. This means, of course, that physicians unwittingly may be hindered in their evaluation of the responses of their patients to prescribed drug therapy.

It would be a revealing experience for hospital administrators, directors of nursing, and even chiefs of staff to make a careful study of the medicine cabinets within their respective institutions. In some it would be noted that medications are labeled and placed in the cabinet according to the patient for whom they have been prescribed and who will presumably pay for them.

The nurse who prepares these drugs for administration must be concerned with the name of the "owner" of the pills as well as with the name of the drug. If by chance the patient's bottle of Equanil is empty, it may be necessary to borrow from the bottle of another patient. Not only must the nurse remember to replace the tablet or tablets for the purpose of proper charges, it is quite possible also that the second patient's bottle may not even be labeled Equanil but may instead be marked Miltown. And what if it is the practice of the hospital to label all bottles with official (U.S.P. or N.F.) or Council (N.N.D.) names but physicians prescribe by various proprietary names? In this instance the bottle will be marked meprobamate and the nurse must then be able to relate three different names, all referring to the same product.

In some hospitals this problem is partially resolved by labeling bottles with official or Council names, with the name under which the drug is marketed in parenthesis. This is quite simple in the case of drugs like chlorpromazine, marketed only as Thorazine. But what of drugs like reserpine, which is known also as Rauloydin, Raurine, Reserpoid, Roxinoid, Sandril, Serpasil, Serpate, and Serploid? While this is admittedly an extreme example, many drugs have two or three different brand names.

The names of drugs are confusing in other ways also. How is it possible to explain that the physician who writes

The nursing station is no place to compound medication mistakes

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It's the nurse who has to

"atropine" really means "atropine sulfate" but when he writes "quinine" he might have in mind "quinine sulfate," "quinine bisulfate," or "quinine hydrochloride"? Does the nurse assume that the quinine salt that is stocked in the medicine cabinet is the preparation that the physician wished to have given when he ordered quinine? Does it make any difference as far as the patient is concerned? If it doesn't, why are there three compounds? Can anyone deny that succinylsulfathiazole and phthalylsulfathiazole are difficult names for those not well versed in chemistry?

Even those who support the use of official and Council names for purposes of simplification find it difficult to insist upon the use of bishydroxycoumarin when the proprietary name Dicumarol is so much easier to spell and to pronounce. How can the young nurse be expected to remember that it makes no difference in the effect upon the patient if codeine phosphate is substituted for codeine sulfate but that there may be a difference if nicotinic acid is substituted for nicotinic acid amide.

Examples such as these are legion. They continue to increase more rapidly than would readily be believed by anyone except the nurses who have to reconcile the names that are written in the doctor's orders with those that are found on the labels of the bottles.

Must Know Two Weight Systems

In spite of the fact that for some time the "United States Pharmacopeia," the "National Formulary," and "New and Nonofficial Drugs" have included only metric doses, it is still necessary for nurses to be able to cope with the apothecaries' system as well. The perpetuation of this outmoded system in hospitals contributes to difficulty in learning mathematical computation and increases mistakes in dosage during administration of drugs. It is not uncommon for nurses to have to change quickly and frequently from doses written in grams to those written in milligrams to those written in grains. How commonly one sees in the same order: Morphine Sulfate 0.01 Gm. and atropine sulfate gr. one-one hundred fiftieth. This is as though we used both the American and British system of coinage and in paying for a long list of items some were charged in one system while the remaining items were charged in the other system.

Further, in many hospitals, some bottles are labeled in the metric system while others are labeled in the apothecaries' system. To carry the analogy further, the person paying for the items referred to might have some British coins and bills and some that were American. How many

reconcile doctor's orders with the name on the bottle

of us would be able to do the necessary figuring quickly and without error?

Even in hospitals where the metric system is used exclusively there are problems. Since true metric equivalents are rarely used, the nurse needs to know when the margin between the dosage stated on the label of the bottle and that prescribed by the physician is greater than is permissible, usually stated as 10 per cent. For example, a common dosage of atropine sulfate is 0.000426 Gm. This is the true metric equivalent and is rarely used. Substituted for it may be any one of the following: 0.0004 Gm., 0.00042 Gm., 0.00043 Gm., 0.00044 Gm., 0.00045 Gm., 0.4 mg., 0.42 mg., 0.43 mg., 0.44 mg., 0.45 mg.—or gr. one-one hundred fiftieth if the apothecaries' system is also used. Is there wonder that nurses become confused?

Must Spot Toxic Symptoms

The recognition of toxic symptoms of drugs is often considered to be the responsibility of the nurse. In this day of potent drugs it is a major feat to remember all the bad results that may follow their administration. For example, the 1958 edition of "New and Nonofficial Drugs" lists the following effects that may be a complication of the use of glucocorticoids: mental symptoms, facial rounding, abnormal fat deposits, fluid retention, excessive appetite and weight gain, hypertrichosis, acne, striae, ecchymosis, increased sweating, pigmentation, dry scaly skin, thinning scalp hair, increased blood pressure, tachycardia, thrombophlebitis, decreased resistance to infection, negative nitrogen balance with delayed bone and wound healing, headache, weakness, menstrual disorders, accentuated menopausal symptoms, neuropathy (including neuritis and paresthesias), fractures (osteoporosis), peptic ulcer (activation, perforation, hemorrhage), decreased glucose tolerance, hypopotassemia, adrenal insufficiency, polyarteritis nodosa, impaired renal function, lupus erythematosus-like changes, and, in children, hepatomegaly and abdominal distention.

Who could remember all of these? Admittedly, some are more important than others and some could be discovered only by physicians. Admittedly, also, few drugs cause such a large number of complications.

Sometimes it is the *uncommon* toxic symptom that is most important for the patient. Most nurses remember fairly well the common toxic symptoms that follow overdosage from digitalis because they are emphasized so much in the pharmacology course and are seen quite frequently. The nurse also may have "learned" that disorienta-

The Wrong Ampule Can Kill

THE ordering of a drug by "ampules" can result in tragedy. Several years ago, for example, the same drug was available in ampule form for use in the eyes and for injection in the treatment of postoperative urinary retention. The ampule for use in the eyes contained 150 mg., and the ampule for use in treating postoperative urinary retention contained 0.25 mg. Both ampules had the same trade name. In 15 known instances the ophthalmic product was inadvertently substituted for the injectable solution and all 15 patients died within a few minutes of the injection. In most if not all cases the physician simply directed that one ampule be given.

Fig. 1. Table of Equivalents

mg.	Gm.	gr.	mg.	Gm.	gr.
600	0.6	10			
300	0.3	5			
100	0.1	1 1/2			
60	0.06	1			
50	0.05	3/4			
40	0.04	2/3			
30	0.03	1/2			
25	0.025	3/8			
20	0.02	1/3			
15	0.015	1/4			
12	0.012	1/5			
10	0.010	1/6			
8	0.008	1/8	0.8	0.0008	1/80
6	0.006	1/10	0.6	0.0006	1/100
5	0.005	1/12	0.5	0.0005	1/120
4	0.004	1/15	0.4	0.0004	1/150
3	0.003	1/20	0.3	0.0003	1/200
2.5	0.0025	1/25	0.25	0.00025	1/250
2	0.002	1/30	0.2	0.0002	1/300
1.5	0.0015	1/40	0.15	0.00015	1/400
1.2	0.0012	1/50	0.12	0.00012	1/500
1.0	0.001	1/60	0.1	0.0001	1/600

How To Reduce Confusion

THE policies of the institution with reference to drug therapy should be available in written form. These policies should be made known equally to the physicians who write the orders and to the nurses who administer the drugs. Physicians and nurses should be held equally responsible for adherence to the policies. It should be made clear to the medical staff that the medical council, or its equivalent, and the hospital administration, not the nursing staff, constitute the authority behind these policies.

Suitable steps should be taken so that possibilities for confusion of names are kept to an irreducible minimum. Bottles should be labeled consistently with U.S.P., N.F., or Council names, with proprietary names in parentheses. Physicians should be encouraged to use U.S.P., N.F., and Council names in their written orders. A source of information should be readily available for both physicians and nurses, such as the current edition of "New and Nonofficial Drugs" or "Physicians' Desk Reference," or mimeographed or printed lists of names that have been alphabetized and cross-indexed.

Serious attempts should be made to simplify dosage. All bottles should be labeled in the metric system and orders for dosages of drugs should be stated in this system. Quantities less than 1 Gm. should be expressed as milligrams — 0.6 mg., rather than 0.0006 Gm. Simplified fractions should be substituted for the more confusing ones that are sometimes written one way and sometimes another — 0.4 mg., rather than 0.42 or 0.43 mg. Reference tables of equivalents should be available for use by physicians and nurses. (See Fig. 1 on page 95.)

All medication orders should be written so that they are not susceptible of misinterpretation. For example, abbreviations should be so clear that there can be no doubt as to what is meant and drugs to be given by hypodermic or intramuscular injection should be so marked. Drugs that are prepared in ampules should be ordered by quantity of drug, and not by ampules. (See box on page 95.)

Some form of written identification of patients should be available at all times and the method preferably should be uniform throughout the hospital.

There should be a careful evaluation of the status of charge drugs. The cost of paper work by nurses, of the bookkeeping, of the handling and labeling of extra bottles by the pharmacist, of the cluttering of the medicine cupboard by several bottles instead of one or two stock bottles, and of the handling of several bottles by nurses, instead of one bottle, should be balanced against the cost of the drug itself. The one is tangible; the other may be less tangible, but is nonetheless real.

Nurses should be encouraged to consider any new and unexplained symptom that the patient develops as a possible toxic symptom of a drug he may be receiving. ■

tion and confusion sometimes occur, especially in the elderly person who has arteriosclerosis, but is unlikely to remember it until a patient with these symptoms has been observed and their disappearance noted following the reduction in dosage of the digitalis.

But does the relative rarity of the symptom make it less important for the patient? Recently, an aged patient who had been hospitalized for rehabilitation was confused, disoriented and lacking in motivation. When a discerning physician recommended the temporary withdrawal of the digitalis, the patient's response was indeed striking.

The identification of patients may in itself present a problem in this day of part-time nursing personnel. Too many nurses have learned the hard way that it is possible always to call a patient by name before giving a medication, only to discover on one occasion that the patient who answered was not the person for whom the drug was intended.

Each hospital must determine its own way of assuring proper identification of its patients. Whatever the way, it should make possible the *reading* of the name and should be consistently practiced.

I have been intimately concerned with the instruction of nurses in the administration of medications for 30 years. These years have seen some of the most dramatic progress of all time in the use of drug therapy. Along with the advancement of therapy, and hence of benefit to the sick, has come an increase in hazard to those receiving therapy.

If the time-worn admonition that the "cure must not cause more harm to the patient than the disease" is to be heeded and if, on the other hand, the physician is to have reasonable assurance that his patients are receiving the drugs that he thinks they are receiving, and in the amounts he intends to be given, hospitals should take note of the practices within their walls. Some of these practices may well be hindering rather than aiding their objective of the best possible care of patients.

Often it is much easier to point out difficulties and to criticize existing situations than to offer practical means for assistance. This is no exception. There are evidences all along the way that drug therapy is going to become increasingly complicated and that hazards to patients, as well as benefits, will inevitably accompany this development.

It is well known that practices in hospitals differ widely. In some, each nurse gives only the drugs received by her own patients; in others, a "medication nurse" gives all the medications. In some, only registered nurses or student nurses who have been carefully instructed are responsible for this activity; in others, it is part of the responsibility of the practical nurse. In some, the numbers and kinds of drugs that are stocked in the hospital divisions are controlled to some degree by a pharmacy committee; in others, there are no limitations imposed. In some, verbal orders are given frequently; in others verbal orders are honored only in grave emergencies. In some, new drugs are constantly being evaluated; in others, research is at a minimum. In all hospitals, however, the administration of drugs is one of the major responsibilities of nursing personnel. The suggestions that accompany this article (see box in adjoining column) are made in the hope that they will help point the way toward making easier the responsibility for medications that is for some nurses the most difficult responsibility of all. ■

Marc Woodward

Industry's Role in Drug Therapy

DURING 1958 the American pharmaceutical industry marketed 370 totally new products, of which 44 were new single chemicals, and 109 represented new dosage forms. The armamentarium of the medical profession has increased at the rate of one new product a day, on the average, over the last 10 years.

This significant advance in therapy represented an expenditure of $170 million in 1958 for research and development alone by the industry. This is an all-time high; the expenditure in 1957 was only about $127 million. Some $190 million is budgeted for 1959 for research and development. Prior to World War II much of the initiative in medical and drug research came from Europe, with many of our medications imported. However, the last two decades have seen the American drug industry capture world leadership from other countries in this area, while at the same time expanding its facilities for production to keep pace with the burgeoning world population.

Research programs of drug companies are not generally established and carried out on the basis of products, but are directed to diseases to be prevented, treated and cured, and to finding the agents to accomplish these ends rather than to finding a use for a particular product. The guiding factor in the allocation of money and time spent on research projects, therefore, must be the incidence of the diseases for which a cure or a treatment is sought. The attack on diseases with the greatest incidence is, of course, of the greatest importance to humanity.

Since the pharmaceutical industry has already developed products which have achieved miraculous results in the treatment of many diseases, the second step must be a careful consideration of the adequacy of the products now in use in the treatment of the major diseases. Such things must be considered as their toxic reactions or other side effects,

Quest for new agents to

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cost, difficulty of administration, and long-term stability. Thus, quality control has developed as a service of importance to doctors and to hospitals, as well as to the ultimate consumer, the patient.

When a laboratory develops a new drug, accurate methods of identification and testing must be devised. Specifications must be set, as well as means of determining that every batch of the drug that is prepared will fall within these specifications.

When a physician prescribes a pharmaceutical preparation he must be able to anticipate the response which his patient should get from its administration. For this to be possible, every lot of the preparation must be uniform.

The purity of all the materials that go into a pharmaceutical preparation and the accuracy of the quantities added are the obvious elements of quality control. But there are others, too: stability, for example, as it refers to the maintenance of stated potency over a period of months or years; disintegration time of compressed tablets and dissolution time of coated tablets; sterility of injectable and ophthalmic preparations; viscosity and surface tension of liquids; melting point, and uniformity of taste, smell, appearance and texture. Such care in manufacture is an expensive and time consuming process.

The industry continues to search for new agents to combat human disease and improve human health. In 1958 alone the American drug industry obtained, prepared or tested and screened 114,600 chemicals, mixtures, filtrates and so on, biologically or pharmacologically, according to a recent survey conducted by the Pharmaceutical Manufacturers Association. Of these, 1900 substances were tested in human beings in 1958.

The results of such a vast testing program are reflected in the encouraging pattern change in such public health problems as mental health, diabetes, poliomyelitis, collagen diseases, infant and maternal mortality, and serious infections.

Mental illness is today the biggest medical problem facing this country. More than half of the hospital beds in America are occupied by mental patients. As late as 1955 some 750,000 patients were occupying beds in mental hospitals, while many other hospital patients were in need of mental therapy and many persons suffering from mental disorders were not hospitalized at all.

Since 1953, however, with the introduction of chemotherapy as a part of psychotherapy, the pattern has begun to change. Dr. Paul Hoch, New York State Commissioner of Mental Hygiene, noted that in 1956 the New York State hospital system experienced a decline in the number of patients for the first time in 10 years. He gave credit to the

combat disease results in vast hospital testing program

tranquilizing drugs as a major factor in this improvement. There was at the same time no essential change in the number of admissions.

In July 1958 the Veterans Administration announced that the first nationwide controlled evaluation of tranquilizing drugs had shown them to be markedly effective in reduction of the number and severity of psychiatric symptoms, especially in schizophrenia. The studies bore out previous clinical observations that tranquilizing drugs do not cure mental illness, but that they make patients more responsive to other treatment, enabling them to participate more actively in physical medicine and rehabilitation activities, psychotherapy and other programs.

In addition to a wide choice of tranquilizing drugs the pharmaceutical industry has offered, in recent years, central nervous system stimulates and hallucinogenic agents. These drugs have opened new avenues of therapy and offer considerable hope for chronically depressed psychotics.

Until just a generation ago, a diagnosis of diabetes had only one meaning for the patient: death within 5 to 10 years, if not sooner. Today, after 37 years of therapy with insulin, which was first isolated by Dr. Frederick G. Banting and Dr. Charles H. Best, thousands of previously "hopeless" diabetics are alive.

Now the picture is changing even more. The last two years have seen the development of new oral hypoglycemic agents which reduce the abnormally high blood sugar levels of diabetics. They are not insulin substitutes and do not act like insulin. All that is claimed for them is that they are potent aids in stabilizing the blood sugar levels, but that, of course, is the very essence of the diabetic problem. The sulfonylureas appear most useful for, if not limited to, mild diabetics whose disease sets in after age 40, obese diabetics, adult diabetics, and diabetics who need relatively low doses of insulin. Many of these diabetics are excellently controlled by oral agents alone and released from slavery to the needle. Others may reduce their units of insulin taken in conjunction with oral drugs.

In 1955 when the successful field testing of the Salk poliomyelitis vaccine was announced, the vast productive machinery of the pharmaceutical industry went into action to manufacture vaccine not only for this country, but for many foreign countries as well. Today, polio, which was once the most dreaded disease of childhood, is under control. Acute poliomyelitis dropped 75 per cent between 1938 and 1957, the second year the Salk vaccine was used, according to the U. S. Office of Vital Statistics. Some 72 million persons have had at least one polio shot, but 40 million have neglected this important responsibility, according to Surgeon General Leroy Burney. The production schedules of the manufacturers are geared to the need rather than the demand, but the apathy on the part of the public has made it necessary to destroy millions of doses of the vaccine because it has only a six months' life of usability.

Although arthritis and the rheumatic diseases are among the commonest causes of chronic illness in the U.S. today, with one of every 16 persons in the country afflicted, drug therapy has made great advances in the relief of pain and amelioration of these crippling, painful conditions.

Rheumatoid arthritis, osteoarthritis and rheumatic heart disease and gout have responded favorably in recent years to the therapy of salicylates, gold salts, steroids and corticosteroids and such synthetic compounds as phenylbutazone, an effective antipyretic and analgesic. Penicillin is useful in some forms of rheumatic heart disease. Colchicine, corticotropin, phenylbutazone and probenecid can terminate an acute attack of gouty arthritis within 24 to 48 hours.

However, medical science has still not discovered the cause of these diseases, which still account for 80 million work days each year lost to U. S. industry. This is the same as 320,000 persons' being removed from payrolls in the country, more work days than would ordinarily result from all accidents.

Mastoiditis is a childhood infection — one of the most feared of all a generation ago — which has been all but conquered since the introduction of the newer therapies. For example, the New York City Department of Health says that 5400 cases of mastoiditis were reported in that city in 1933. In contrast, only 50 cases were recorded in 1956. This serious disease is so rare today, in fact, that many young doctors are completely unfamiliar with it.

The remarkable aspect of the disappearance of this condition is as important economically as it is from a health standpoint. In 1939, before antibiotics were developed by the pharmaceutical industry, the over-all cost of a case of mastoiditis amounted to about $1000, including necessary surgery, according to hospital records, and the affliction frequently resulted in death, disfigurement or loss of hearing. Today, about $15 worth of antibiotics will clear up most cases without surgery.

This is only one reflection of the savings for the pocketbooks of patients. The same holds true of pneumonia, a classic example often referred to in medical texts. Maternal deaths in the decade between 1944 and 1954 dropped 77 per cent, principally owing to control of infections with drug therapy. During the same period infant mortality was reduced by 33 per cent, according to the National Health Education Committee.

Most important is the lessening of days a patient must

spend hospitalized during a time when hospitals are overcrowded and the staffs vastly overworked. But the hospitalized patient is not the only one to benefit from the contribution of new drug therapy to the national health picture.

For example, between 1942 and 1956, according to the U.S. Department of Commerce, total personal consumption expenditures for drugs increased by only 122 per cent. During the same time total personal consumption expenditures for all purchases increased 198 per cent. Drug expenditures have dropped from 23 per cent in 1942 to 16 per cent of total medical expenditures. Only 0.66 per cent of the personal expendable income of Americans goes for prescription drugs today.

This is easy to understand when it is considered that the average price of a prescription in our country is only $2.92. Ten per cent of the prescriptions cost a dollar, or under. Nearly 80 per cent cost less than $4. Only 1 per cent in 1957 cost more than $10.

Here are some specific examples: Insulin, literally a lifesaving compound, costs only 6 per cent of what it did 30 years ago; thyroid extract, in the face of a spiralling economy on other commodities, has only increased 0.7 per cent since 1950; streptomycin decreased in price 65 per cent between 1948 and 1956; penicillin has declined in price 99 per cent since 1943, and oxytetracycline has dropped 39 per cent since 1950.

Today Americans spend only about $12 each throughout the year for prescription products. This is less than they spend for tobacco — some $34 per person; alcoholic beverages — $55 per person, and repair, servicing and storage of automobiles — $18 per person.

For the $12 per person spent in this country for prescriptions to help maintain his state of health, relieve his pain, or restore him to a useful place in society, the American citizen realizes the best bargain in the history of health. The American doctor spends less time per patient because of the new and more effective tools at his disposal. The American nurse can devote more time to patient care, and more hospital beds are available to more suffering persons than ever before. ■

How To Make Pills and Tablets

TABLETS are the most widely used method of administering medicines by mouth today. They are a progressive development from two older dosage forms, powders and pills.

Powders represent one of the oldest forms for administering medicines. They are a natural outgrowth of man's attempt to prepare crude drugs and other natural products in a convenient form. Many powders are still used orally and topically, or are prepared for use by pharmacists in compounding extemporaneous suspensions and solutions.

Pills were a step toward aggregating powders into units. In preparing pills, a soft moistened mass was rolled into a pencil shape. This was cut into small quantities and pills were rolled into globular form. Pill-making was one of the "arts" of the old-time pharmacist, and pills were the most extensively used form of medication. They have been largely replaced today.

Tablets, as distinct from pills, are masses of solid medicinal substances compressed into shape. The tablet was invented in England by William Brockedon in 1843.

There is more to tablet-making than appears at first glance. It is not just a matter of compressing the powdery, crystalline or granular material into shape. If the single dose of the active ingredient going into a tablet is too small to permit the tablet to be compressed in the machine, an inert substance—a base such as lactose (milk sugar), for example—is added to the formula to bring the tablet up to a convenient size and weight.

Sometimes a disintegrator is necessary. This is a substance like corn starch or potato starch, added to cause the tablet to break apart in water. Starch has a great affinity for water and swells when moistened. An effervescent disintegrator—sodium bicarbonate and citric or tartaric acid, balanced to produce a neutral combination in water—is sometimes used to produce rapid distintegration. When a tablet is placed in water, carbon dioxide gas is formed which breaks the tablet apart rapidly and causes the solution to bubble.

Most drugs refuse to form a satisfactory tablet by themselves no matter how much pressure is used. Thus, a binder—some adhesive substance like glucose —must be mixed with the medicinal chemical. In addition, a lubricant like stearic acid is often added to prevent the tablets from sticking to punches and dies.

Many of the refinements added to pill-making in the 19th Century have been carried over into tablet manufacture. One such improvement was the "friable pill," made so that it would crush easily. Another was the sugar-coated pill. The first sugar-coatings were made by placing the pills in a flat copper-coated pan and covering the pills with sugar sirup. The pan was then swung over open fires and, as the water in the sirup evaporated, the pills, rolling back and forth, were left with an even coating of sugar.

The term "sugar-coating the pill" came, of course, from the use of a coating to mask the unpleasant taste and odor of medicines. But compressed tablets and other dosage forms may be coated for several other reasons:

1. To protect the ingredients against air and moisture.

2. To prevent interaction between two drugs incorporated in the same tablet. Such tablets are laminated—made in multiple layers. One ingredient is placed in the "core" of the tablet, for example, while a second is incorporated in the coating.

3. To improve the appearance.

4. To control the site of disintegration. These are termed "enteric-coated tablets." The coating consists of a substance that resists solution in the stomach but disintegrates in the intestine. ■

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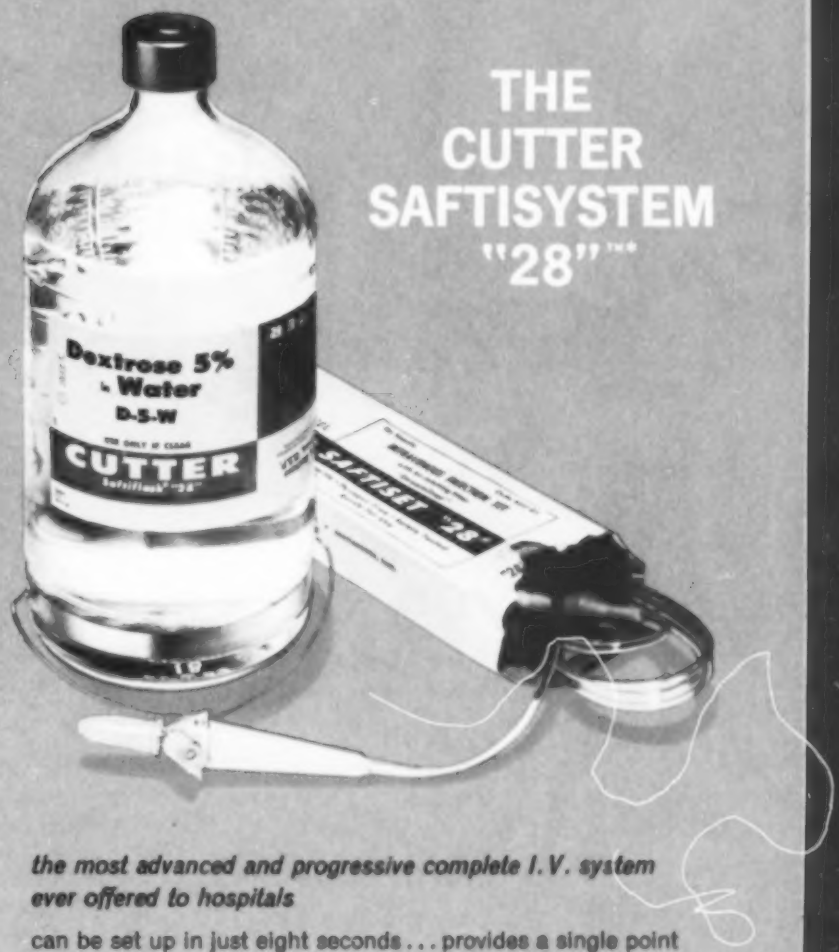

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Medicine

and Pharmacy

Grover C. Bowles Jr.

A Pharmacist Views Drug Therapy

THE primary function of the pharmacist in today's modern hospital is to provide the best pharmaceutical service available to patients and the hospital staff. Adequate pharmaceutical service in the modern hospital, however, includes far more than dispensing drugs for patient use and the filling of requisitions for routine pharmaceutical supplies.

Physicians and nurses often turn to the pharmacist for detailed information about drugs — their use, dose, contraindications and possible toxicities. With the marketing of one drug product per day for the last 10 years, the physician frequently needs to turn to the pharmacist for comparisons of similar drug products within a specific pharmacological classification. The hospital pharmacist must have the ability to sift out special information and be able to organize it in an accurate manner which will be most meaningful to the doctor and nurse.

To provide this type of consultative service, the pharmacist should maintain an up-to-date library. He needs the standard textbooks dealing with pharmacy, pharmacology, chemistry, toxicology, clinical pathology, and microbiology. More important, he must have the most frequently read medical and pharmaceutical journals. In addition to the textbooks and journals, many pharmacists maintain a current literature file for filing and cross-indexing information on new products, reprints, clippings and other pertinent information on drugs too new to be found in the textbooks.

Some pharmacists publish pharmacy bulletins or newsletters to supplement the day-to-day requests for information about drugs. These publications provide a method of disseminating information about new products and a convenient means of communicating with the physicians and nurses on the hospital staff.

Perhaps the pharmacist makes his most positive contribution to the hospital drug therapy program through his activities as secretary of the pharmacy and therapeutics committee. This important group is an advisory committee of the medical staff. It is concerned with the formulation of broad policies for the handling of drugs within the hospital. The pharmacy and therapeutics committee is also responsible for evaluating and selecting those drugs which are most useful therapeutically and for the publication of the hospital formulary. As secretary of this important committee and usually the only continuing officer, the pharmacist is in a unique position to help mold and carry out the group's long-range objectives.

Specifically, the long-range objectives include:

1. Publication of the drug formulary. If the American Hospital Formulary Service is used, the P&T Committee merely selects the monographs from among those supplied by the formulary service. However, it would be necessary for the local committee to prepare monographs for those drugs not described. The establishment of a drug formulary may not appear to be a long-range objective but in practice it becomes one.

2. Development of good safety practices relating to the use of drugs. This objective is accomplished largely through an educational approach by making sufficient information about drugs available to the medical and nursing staffs. The investigation of all errors in the administration of drugs would come under this heading. The committee might also want to make suggestions for the proper labeling of drugs and develop a list of approved abbreviations for use in prescribing drugs which might help prevent errors from occurring.

3. Proper handling of investigational drugs. This would be accomplished by encouraging the investigators to furnish the committee with all the information available about the investigational drug and requesting the pharmacy to dispense the drug on his (investigator's) order. The committee might even go as far as to recommend certain policies for the handling of investigational drugs to the hospital.

4. The development of a rational drug therapy program. This is accomplished through a never-ending educational campaign aimed at the medical staff and should be the ultimate goal of all pharmacy and therapeutics committees. The

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development of a drug formulary and good safety practices relating to the use of drugs would be part of this program. Included also would be the publication of a pharmacy and therapeutics committee bulletin containing information about new and frequently used drugs and arrangements for brief reports on drugs of current interest at staff meetings.

Because the pharmacist is the only continuing member of the committee it is up to him to provide the continuity from year to year as the committee membership changes.

Fortunately, the availability of the American Hospital Formulary Service eliminates the laborious task of preparing a formulary in each hospital. The pharmacy and therapeutics committee in hospitals subscribing to the American Hospital Formulary Service merely selects the drug monographs which it feels are most useful therapeutically from among the 600 monographs supplied by the service. Continuing supplements are made available by the formulary service; this enables the committee to keep its formulary current. Taking advantage of this service, the individual pharmacy and therapeutics committee need only to prepare monographs for the drugs used locally but not widely used in other areas of the country. The chief advantage of the American Hospital Formulary Service is that it provides a ready source of accurately prepared drug monographs which are kept current through constant revision. Thus the hospital's pharmacy and therapeutics committee, freed of the time consuming task of writing drug monographs, can spend more time in selecting drugs for use and in the formulation of broad general policies for the control of drugs.

Increasing emphasis is being placed on the part played by the pharmacist in the safe handling of drugs. The American Hospital Association has officially recommended that "hospital pharmacists extend their reponsibilities to include participation in programs dealing with the safe handling of drugs throughout the hospital." Since poison control centers are usually located in hospitals, the pharmacist should have available information about the content of commercial preparations, toxicology and suggested antidotes.

Investigational drugs undergoing clinical trial are commonplace in most hospitals today. From the standpoint of safe handling and proper dispensing, the pharmacist has much to offer. Frequently the investigational drug is not available in the dosage form desired so the pharmacist may be asked to prepare sterile solutions for injection, sirups or other formulations.

Today's hospital pharmacist should participate in the educational program of the hospital. Because of his close contact with the medical staff, particularly the resident staff and the nurses, much of his teaching will be informal. He may, however, teach pharmacology in the school of nursing and lecture to the student laboratory technicians, student x-ray technicians, and medical record librarians, and take part in other formalized training programs in the hospital. The hospital pharmacist should also be prepared and available to speak at medical staff conferences, to graduate nurse groups and other such groups.

Each new research, diagnostic or patient care area presents new pharmaceutical problems. The modern hospital pharmacist should have the initiative and the ability to cope with these problems and make tangible contributions to better drug therapy. ■

Pharmacy Committee Agenda

1. Is our hospital formulary receiving maximum use?
   (a) Rules for admission of new drugs to formulary.
   (b) Review of present formulary drugs for the purpose of eliminating those now obsolete.
2. Should the usage of certain drugs be controlled or restricted?
   (a) Because of adverse reactions or toxicity.
   (b) Held in abeyance for emergencies (certain antibiotics for possible staphylococcus infections).
3. Discussion on dietary drug supplements.
4. Discussion on comparative costs of certain drugs.
5. Use of generic terms by staff instead of trade names.
6. Rules on "substitution of comparable drugs" when allowed by hospital by-laws.
7. Policy on drug representatives and detail men.
8. Hospital rules on "going home" prescriptions.
9. Discussions on preference and dangers of intramuscular *versus* intravenous route drugs.
10. Discussion on use of "one shot" high potency drugs *versus* multiple, more frequent injection with consideration of costs, pain and irritation to patient, and saving of nurse's time.
11. Is the "stop-order" understood and functioning?
12. Centralization of reports on drug reactions.
13. Routine use of antibiotics. Uses and abuses.
14. Review and restudy the storage, handling and prescribing of narcotics.
15. What can we do to educate the staff and promote better quality patient care through the pharmacy committee?

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Operating Room Forum

Precise Procedures Are a Must To Combat Infection Problems

By Frances Ginsberg, R. N.

Frances Ginsberg

THERE are literally thousands of ways in which any deviation from exact procedures gives organisms an opportunity to gain a foothold and flourish. There is no question that this is clearly understood in most hospital operating rooms, yet some practices continue because of the human failing that "we can't think of everything." We *must* think of everything if we are going to cope intelligently with the problem of infection.

One of the things about which people don't often think is the scrub suit or dress. If, in fact, they are what their names imply, uniforms designed to reduce the number of organisms brought into an operating room, then they should be considered, used and handled as such. Unfortunately, this is too often not done. The freshly laundered, clean, cotton garb should be worn only in the operating suite and not worn around the hospital. If it is worn elsewhere, it should be changed before reentering the suite. This is one of the singularly most difficult rules to establish and doubly difficult to enforce.

The same basic rule should be applied to conductive shoes or booties. These should not be worn outside the operating suite for the obvious reason that floors, particularly waxed floors, are one of the best breeding places for organisms. The soles and heels of shoes are an ideal way for bacteria and dirt to travel into strategic areas. Shoes worn in the operating suite area should be cleaned regularly. This cleaning process should be the individual responsibility of the wearer and should include cleaning soles and heels with a fine wire brush followed by a germicidal solution. Tops of shoes should be scrubbed clean to eliminate dried blood or organic debris. It is appalling that some surgeons view the accumulation of organic debris on their shoes as a measure of their surgical prowess. For those who feel that this point is overemphasized, I suggest that a few culture tests be done on the shoes now being worn by operating room personnel.

Although not closely related to the question of attire, I would like to add one other factor that should be considered in any program for infection control. That is the terminal sterilization of instruments before handling. The most effective method to sterilize instruments is in a pressure-washer sterilizer immediately after use. Instruments should neither be left around to wait for sterilizing all together, or for a less busy period. Where there is a pressure-washer sterilizer, they should not be hand washed first and then sterilized. This method is more of a preventive procedure than a corrective one. It reduces the microbial population of the area as well as protects personnel from contacting possible pathogens and carrying them elsewhere.

These past few columns have pointed up certain practices which can help contribute to the control of hospital infections. If each of the points is evaluated critically and then adapted to each hospital, these factors, combined with improved housekeeping and laundry practices, should help reduce the incidence of infections in patients and personnel. ■

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to give your surgeons stronger,
more pliable surgical gut.
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How To Promote and Assure Rational Drug Therapy

(*Continued From Page* 89)

There may be still an occasional questioning turn of the head when committee consideration of avoidance of duplication of drugs, stop-orders on dangerous drugs, or review of drug therapy via medical records are mentioned, however. Drug manufacturers with sizable investments in research and in development of brand name products are quite naturally interested in sales and in returns of profits on their investments. Without these they have a sick business. They are understandably concerned when any suggestion of unauthorized substitution for a named product of their's arises. Most of them also recognize the practical impossibility of asking each hospital pharmacy to stock regularly all available brands of many basic substances, and agree that the medical staff of a hospital may concur in writing to the principle of providing drugs under their generic names, leaving to the hospital pharmacist the selection of the brand to be stocked. There are several excellent published discussions of this subject.

Good drug therapy in the modern hospital requires the continuing efforts of many people. Ways of abetting it are legion but the physician, nurse, pharmacist or other person chosen to serve on the pharmacy and therapeutics committee will find the experience stimulating, challenging and full of potential satisfaction through opportunity for a real contribution to better patient care. ■

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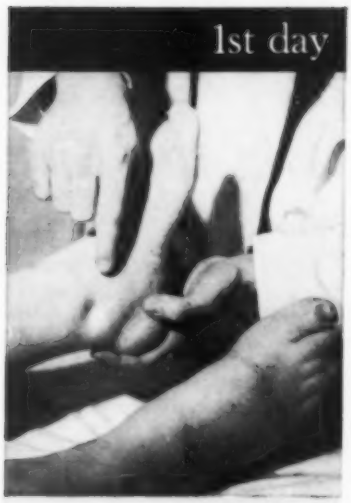
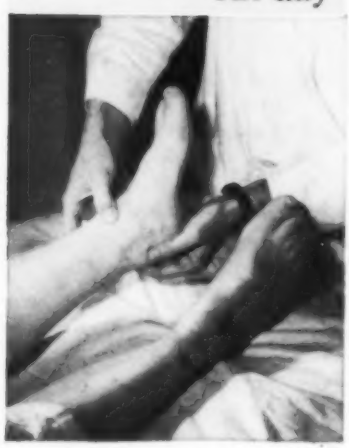


Record of patient with congestive failure treated at a leading Philadelphia hospital. Photos used with permission of the patient.

marked pitting edema (4+) cleared in 4 days with Esidrix

4th day



L.S., 81 years old, admitted to hospital 3/3/59 with hematuria, arteriosclerotic cardiovascular disease, poorly compensated heart failure. When 4+ pitting edema, hepatic congestion and râles failed to clear on regimen of salt restriction, digitalis and pulmonary decongestants by 3/6, Esidrix 50 mg. b.i.d. was ordered. By 3/8 L.S. had lost 3 pounds, pitting edema was reduced to 1+, râles decreased. Patient was ambulatory on 4th day of Esidrix therapy; no evidence of edema. He was discharged feeling well on 3/14.

Now...for edema and hypertension

Dosage: Average daily dosage (orally) is 75 to 100 mg., with a range of 25 to 200 mg. A single dose may be given in the morning or tablets may be administered 2 or 3 times a day.

Supplied: Tablets, 25 mg. (pink, scored); bottles of 100 and 1000. *Tablets,* 50 mg. (yellow, scored); bottles of 100 and 1000.

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Conducted by Mary P. Huddleson

How To Keep Out of Trouble in the Kitchen

Trouble usually starts with bad planning, but attention to details of design, materials and location of kitchen equipment can prevent small oversights from becoming major problems

Elizabeth Miller

DIETITIANS often say, "I wish I had known some of the mistakes that are made in building and in equipment before I worked with the architect in planning this building." Or: "I wish I knew more about these things so I could check plans as we go along." There are several practical problems to consider in planning interiors and specifications for equipment.

From visits to many hospital kitchens and my own work I have observed a few of the problems with equipment that could have been avoided had they been more carefully studied.

Cupboards *vs.* Shelves. Stainless steel is beautiful in a kitchen but don't plan for more than you need. It requires much cleaning. Many of the cupboards in a kitchen are never used. They are wonderful places for an employe to put a banana which he thinks he will want later and never thinks of again. From experience, I believe in *few* cupboards and *many* shelves so one can see what is there. Shelves are cheaper, too. I don't even like a lot of drawers in the worktables. Check — pull them out and see what you will find.

Storage Space. Don't forget to plan for storage rooms. They must be well ventilated (especially for food storage) and not put in the leftover space with hot pipes above. Their placement should be decided in the original planning. It will cost thousands of dollars to correct this mistake later. It is a common mistake and, frankly, there is no excuse for it.

Linen Room. In any large institution I like a ventilated soiled linen room. Some have chutes for soiled linen, but how can we keep track of linen that way? Some cities object to mixing table linen and patient linen even though they are sterilized later. This should be checked before the chute is installed.

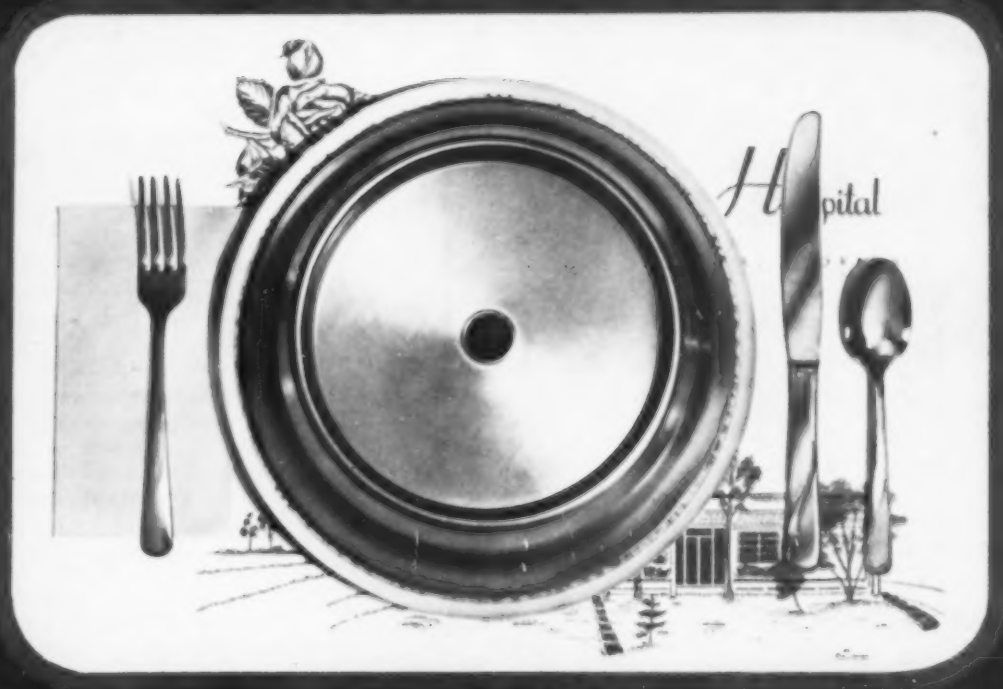
Placement of Drains. Quite a few drains are needed. Some city or state regulations specifically state that drains are not allowed within the refrigerator. In that case, put them outside, with a slope leading down to the drain. Have enough drains in the kitchen, and have them where they are needed. Don't forget to have a drain in the scale pit, where incoming produce is weighed. Grease and water from the general wash-down will collect there and cause an unpleasant odor, as well as ruin the scale, if this water isn't drained. Hospitals should be sure to have hot water in the receiving, garbage and trash rooms so they can be thoroughly cleansed and washed down.

Refrigeration. If you have reach-in refrigerators, plan for remote compression. This takes all parts away from the hot kitchen and produces better results. Do not use a plastic trim on deep-freeze boxes. Plastic will not withstand temperature changes. The plastic trim cracks and in a short time must be replaced. There are a number of deep-freeze reach-in refrigerators on the market which answer the need for many purposes. Do not completely fill this box because circulation of air must be allowed. The outside thermometer on a refrigerator must be installed properly to avoid a differential in temperatures. Walk-in refrigerators should be even with the floor so trucks can be wheeled in. Two-door walk-in refrigerators are valuable if they are used from both sides.

Potwashing Sink. Always plan a three-compartment sink for potwash-

Elizabeth Miller is in charge of the inservice training program at Eastern Pennsylvania Psychiatric Institute, Philadelphia. For 32 years she was with the dietary department of Philadelphia General Hospital, first as assistant, and later, as chief dietitian. While she was there she helped with the planning of the new foods building. Miss Miller retired in 1954, but soon left retirement to help fill the need for hospital nutrition instructors. She taught for one year at Pennsylvania State University.

TRAY THERAPY



Sometimes it takes more than medicine to make patients feel better. Roylprints and Roylies (printed paper place mats, doylies and tray mats) lend brightness to tray meals... perk up lagging appetites. You achieve a crisp, sanitary look.
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ing, with a final spray rinse. Open racks are best to stand pots on to dry. Again, a drain is needed under this spot.

Dishwashing. Plan this unit with great care. It needs sufficient space for the work that is to be done and should not be just a boxed-in dishwashing machine. Plan to overcome noise; to provide storage, and to furnish some comfort for the employe.

Make sure electrical outlets are sufficient in number and voltage to carry any equipment that may be added later. Steam lines and plumbing lines need to be large enough for the work that is to be done.

In drawing up specifications, make sure they tell what you really want. In purchasing complicated equipment for an older building, be sure the specifications call for *installation* of that equipment.

Consider These Points

Now for a few questions and points to consider regarding equipment:

Are the height and location of grills correct and can you clean behind them?

Did you plan for "sneeze bars" on all food counters? Many cities are particular about this point. The closed tray shelf at cafeteria counters is preferable to rods. If something is spilled it doesn't splash over the next person's feet and dress and it can be easily cleaned up.

Check milk dispensers. Plastic tubes that are too long are objected to by many sanitary inspectors.

Vertical oven tiers are easy to use and to clean, and save space. Flat-top ranges are invaluable and, of course, some open style ranges are needed. Radar cooking may be coming, but it is a little expensive as yet, and has not been sufficiently perfected for general use.

Check Specifications

Steam cooking is a necessity and must be provided. Hoods over ranges and steam cooking units must be carefully ventilated. Be sure the exhaust is such that it will carry off steam and odors, otherwise odors will penetrate the building.

If you have coffee urns, make sure specifications call for a holding urn or a making urn, whichever you need. The wrong type can really cause trouble. Should the coffee urn have an exhaust over it? There are kitchens using a newer type of exhaust than that requiring hoods. Is it satisfactory? Look into it before planning.

Deep-fry kettles need lids. Think of what this means to you! Lids should be a standard or integral part of the kettles.

Bins on wheels for sugar, flour and so forth are a necessity in every kitchen. That means worktables must be planned so there will be space underneath for these bins to slide in out of the way. Trucks and tables should be on wheels. I prefer dollies to rubbish and garbage cans with coasters as they are easier to clean.

Plan for tray conveyors for trays and soiled dishes.

Asbestos tubing looks nice when it's fresh — horrible after much use. Aluminum paint is wonderful for this purpose. Do not paint the interior of any equipment, such as ice cream serving units, with anything other than aluminum paint.

There are many other considerations that could be mentioned. In planning kitchen equipment study your needs, make up your mind what you want, be sure you are right, and go ahead. ■

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Cream Sauce Adds Magic to Meals

Blend in versatility and appeal when you add cream sauces to vegetables, casseroles, soups, meat and seafood dishes. Methods of preparation include the roux, conventional and a new simplified white sauce base

Doris Zumsteg
Teaneck, N.J.

CREAMED foods have special importance in hospital food service. They can play an important role nutritionally, meeting the need for milk, broth, carbohydrate, vegetable juices, easy-to-eat meat, and fish. In the therapeutic diet, the physical aspects of blandness and softness give added importance to cream sauce. In addition, creamed foods lend variety to hospital menus, and they can be both attractive and tasty.

Technically, the term "creamed" means actually made with cream. However, the popular white sauce prepared from a combination of flour, fat and milk often goes by the name of cream sauce, and items prepared with it are called "creamed." If the liquid used in the sauce is a stock or broth, the sauce is rightly called Bechamel sauce, although foods made with it are also called creamed.

While the creaming process can serve profitably to "stretch" more expensive items like lobster which could not appear in some menus otherwise, it should never be used to "cheapen" the food.

It is essential that the white sauce be prepared the same way for the same purpose every time. Thickly creamed, sticky vegetables one time and "soupy" ones the next; tastily seasoned pimiento sauce once and a nondescript something the next time can spoil the entire meal.

There are two general procedures for preparing white sauce, each with its own devotees.

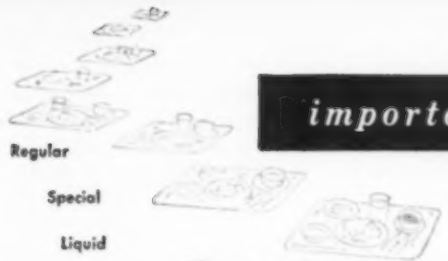
The Roux Method. The cook first prepares a combination of fat and flour which he adds to the warm liquid, usually using a wire whisk.

The Conventional Method. The

Ingredients for two tasty casseroles. The cooked spaghetti, chicken, grated cheese, and medium white sauce make Chicken Tetrazzini. Rice, flaked fish or shellfish, curry powder, and thin white sauce combine into curry.

Two dishes at top show the Chicken Tetrazzini ready for serving, topped with slivered toasted almonds. The plate of curry is trimmed with broiled banana. The dishes will be covered with aluminum foil to keep cream sauce moist.

important FOOD SERVICE news

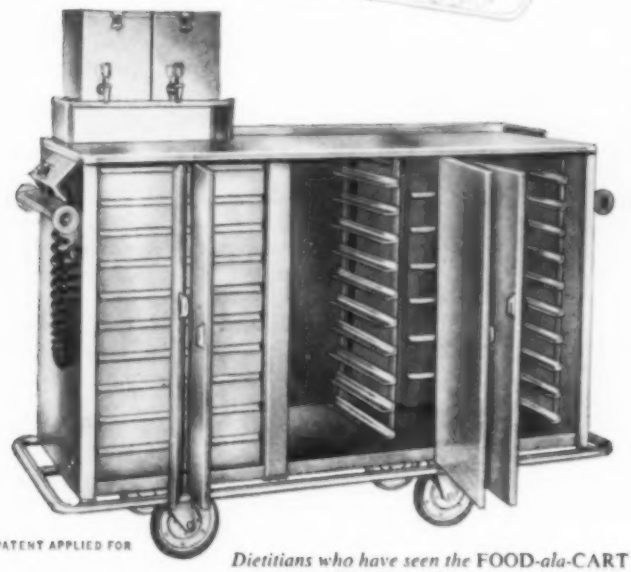


The all new Nutting FOOD-*ala*-CART System

ends "DIET TRAY CONFUSION!"

Here for the first time is a food service system that ends one of the biggest problems facing dietitians . . . "Diet Tray Confusion." FOOD-*ala*-CART is the first and only food service system to provide *one oven drawer* for *every serving tray!*

This exclusive FOOD-*ala*-CART feature ends "Diet Tray Confusion" and makes spot checking easier — more accurate. It also speeds tray assembly — makes it simpler.



PATENT APPLIED FOR

Dietitians who have seen the FOOD-*ala*-CART system say it's the easiest to use equipment they have ever seen. Its design is based on a comprehensive research study among dietitians. These dietitians told us it's not the fixing of the food but the serving that is the big problem. The Nutting FOOD-*ala*-CART answers the serving problem best because it simplifies it, ends "diet tray confusion," keeps foods appetizing, refreshing, delicious tasting right to the patient. It is truly *the new standard of fine food service for hospitals.*

Only the new FOOD-*ala*-CART system offers *all* these features!

- ONE OVEN DRAWER FOR EVERY SERVING TRAY ends "diet tray confusion." It's the easiest to use food service system you have ever seen.
- FROZEN FOOD SECTION keeps frozen desserts served in sliced form, in ramekins or similar containers frozen; even ice cubes won't melt.
- ALL FOODS are served at dietetically accepted temperatures for maximum patient "meal appeal."
- VERSATILE INTERIOR — Easily changed to accommodate 3 different tray sizes; no tools are needed. Can also be changed to handle from 16 to 24 trays. Interior can be easily and entirely cleared for steam cleaning.
- ROLLS EASILY — Large ball-bearing wheels with non-marking rubber tires especially compounded for easier starting, easier rolling.
- COMPACT SIZE makes FOOD-ala-CART easier to handle. Clears any hall, door or elevator opening.
- SAFER — Center hung door panels do not extend beyond cart when open.
- EASIER TO USE — EASIER TO SEE CONTROLS — There's no guesswork about this cart. All controls are up in plain sight, easy to see. Simple switches turn "ON" and "OFF". Refrigeration and heat controls are pre-set — require no adjustment by user.

Everyone is happier with FOOD-*ala*-CART! Patients, physicians, nurses, aids *and* dietitians, *all* like the way FOOD-*ala*-CART eases preparation, keeps foods appetizing and simplifies serving.

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cook melts the fat, stirs flour into the melted fat, usually with a wooden spoon or paddle. The liquid is stirred in gradually.

The roux method is used much more widely. It is standard for cooks trained outside of the United States, and for American cooks who have trained under European chefs. Women cooks frequently prefer the conventional method because it is the one used at home.

There are pitfalls in both. One is lumping, caused by too quick cooking, too high heat, and insufficient stirring. The other fault is inconsistent seasoning because no recipe is used or because the recipe does not list the amounts of seasonings which it requires.

New Base Available

Of interest to the food service industry is the new commercial white sauce base or roux which is ready to use with any liquid – water, milk or stock. The commercial roux is made from fat, precooked flour, nonfat dry milk, seasoned with salt and monosodium glutamate. It is packed in two-pound waxed containers that need no refrigeration under normal storage conditions. Of special importance to the food service department that uses food carts or must hold food on a steam table is the fact that the commercial product does not "break" as do most sauces made with plain flour.

As a work saver, some chefs like to prepare a quantity of thick white sauce, then thin it down as needed. This is practical whether the sauce is made "from scratch" or from the commercial product. In general, it is better if the thick sauce has not come directly from the refrigerator because it is more likely to become lumpy when it is being heated.

If creamed foods or the sauces are to be held after cooking, they should be kept in a double-boiler over hot water. To prevent a crust from forming a small piece of butter can be melted on the surface.

The velvety smooth, well seasoned basic sauce of proper consistency for the specific purpose can dress up many foods.

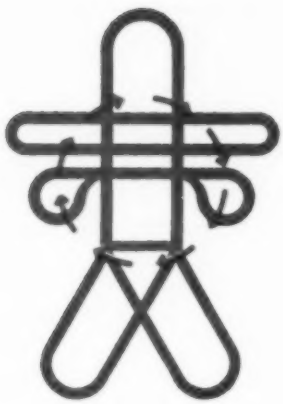
Add to Sauce

But it is not being fair to any food service department to limit the potentialities of the sauce at this point. The addition of an ingredient or two can upgrade the end product, indeed the entire menu.

For example, start with a white sauce prepared in the usual way or double-quickly with the prepared white sauce base. Use half turkey or chicken stock and half water. Finish off the sauce with a little light cream or beaten egg yolks or both. Correct the seasoning. Add lobster, shrimp or crabmeat (and sherry, if desired for special functions) to make a rich Newburg.

The same basic sauce can be used with capers to serve over boiled beef. Instead of the capers, curry powder, chopped tarragon, horseradish or mushrooms can be added to enhance other meats, vegetables, omelets or hard cooked egg dishes.

Fish can rate bold type on the menu when sauces do it full justice. The sauce is prepared as usual with addition of chopped parsley, egg yolk or cream. For the "extra," crab butter, shrimp, coarsely-cut cooked oysters, anchovy butter, or lightly cooked fresh tomatoes and mushrooms can be added to make a more flavorful sauce. ■



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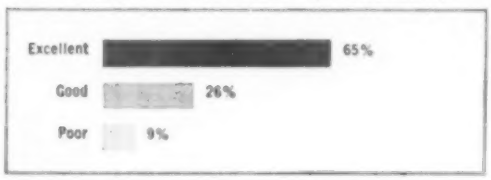
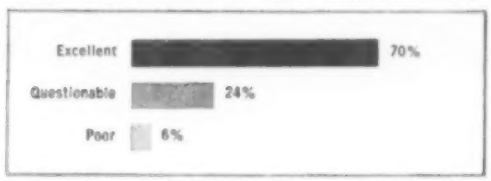
ACTASE IN VENOUS THROMBOSIS (171 PATIENTS)*



ACTASE IN PULMONARY EMBOLISM (33 PATIENTS)*



*Adapted from Singher, H. O., and Chapple, R. V.[5]

SAFETY—In recommended dosage ACTASE does not interfere with blood coagulation.

ADMINISTRATION—ACTASE is administered by intravenous infusion over a 2-hour period. **ACTASE** is most effective when given soon after the formation of the clot. The concomitant use of anticoagulants is recommended. A temperature rise (1° to 5.2° F) may occur with ACTASE. This may be ameliorated with conventional antipyretic therapy.

CONTRAINDICATIONS: Hemorrhagic diathesis; major liver dysfunction; hypofibrinogenemia.

SUPPLIED: Vials of 50,000 Fibrinolytic Units.

Complete information available on request.

REFERENCES: (1) Astrup, T.: Lancet *2*:565 (Sept. 15) 1956. (2) Cliffton, E. E.: Ann. New York Acad. Sc. *68*:209 (Aug. 30) 1957. (3) Cliffton, E. E.: J. Am. Geriatrics Soc. *6*:118, 1958. (4) Sussman, B. J., and Fitch, T. S. P.: J.A.M.A. *167*:1705 (Aug. 2) 1958. (5) Singher, H. O., and Chapple, R. V.: Clin. Med. *6*:439 (March) 1959.

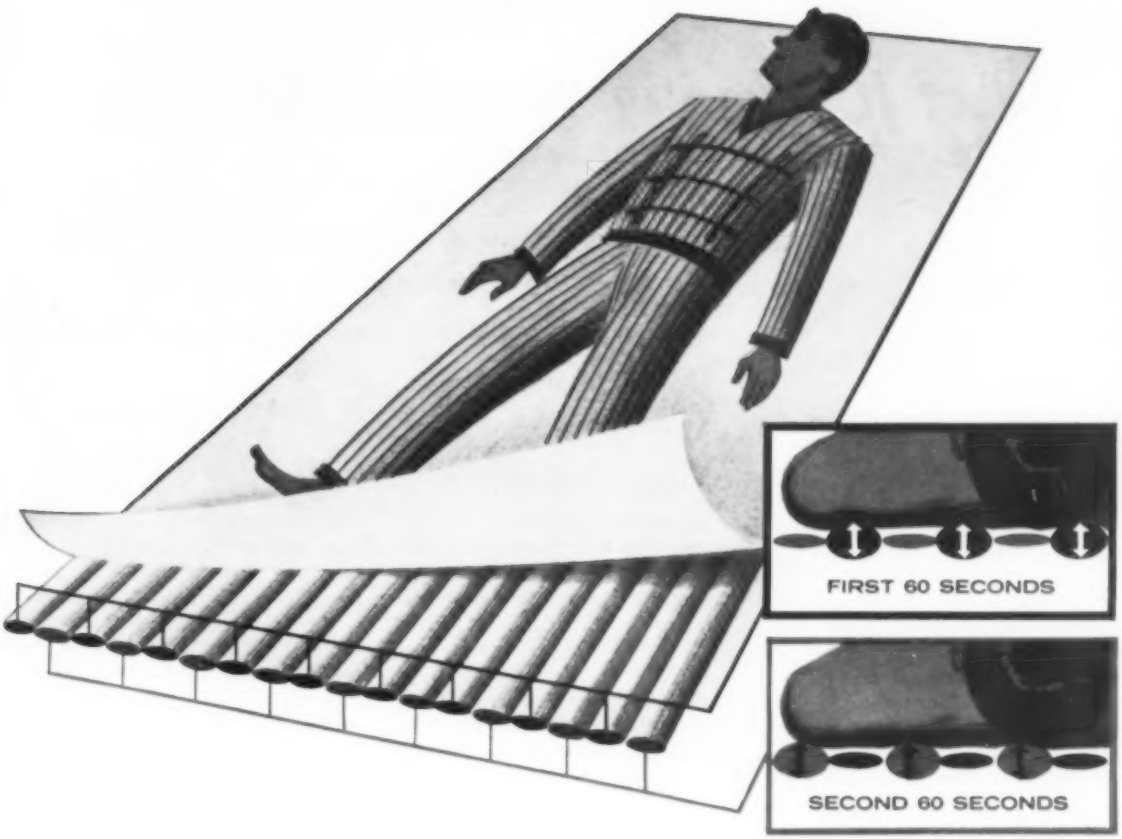
ORTHO PHARMACEUTICAL CORPORATION
RARITAN, NEW JERSEY

Menus for August 1959

Sister Mary Daniel
Director of Dietary Department
St. Vincent's Hospital
Bridgeport, Conn.

1 Orange Juice Scrambled Eggs • Roast Veal Paprika Potatoes Stewed Tomatoes Lettuce Wedge With French Dressing Marble Cake • Cream of Mushroom Soup Hot Roast Beef Sandwich Green Peas Pineapple–Blueberry Salad Butterscotch Pudding Cookies	**2** Banana Pork Sausage • Broiler Whipped Potatoes Lima Beans Cranberry Sauce Neapolitan Ice Cream • Scotch Broth Sliced Ham Potato Salad Sweet Pickles Iced Cupcake	**3** Grapefruit Juice French Toast • Roast Beef au Jus Parsley Buttered Potatoes Frozen Chopped Spinach Deviled Egg Salad Strawberry Chiffon Pie • Vegetable Soup Veal Cutlet Baked Potato Fresh Fruit Salad Gingerbread Square With Orange Sauce	**4** Cantaloupe Crisp Bacon • Sauteed Calves Liver Lemon Buttered Potatoes Asparagus Mixed Green Salad Devil's Food Cake • Creole Soup Meat Loaf With Mushroom Sauce Sliced Carrots Perfection Salad Apple Crisp	**5** Pear Nectar Soft Cooked Egg • Braised Beef Delmonico Potatoes Buttered Peas Date-Orange Salad Strawberry Shortcake • Beef Noodle Soup Canadian Bacon Hot German Potato Salad Stuffed Celery Old-Fashioned Bread Pudding	**6** Stewed Prunes Pork Sausage • Turkey a la King Steamed Rice Wax Beans Tomato Accordion Salad Orange Chiffon Cake • Potato Chowder Corned Beef Hash Peach-Cottage Cheese Salad Baked Custard
7 Vegetable Juice Poached Egg on Rusk • Fillet of Cod Whipped Potatoes Succotash Pineapple-Coconut Salad Cherry Pie • Clam Chowder Creamed Tunafish With Peas Baked Potato Tomato Aspic Salad Applesauce Cake	**8** Apricot Nectar Scrambled Eggs • Veal Fricassee Parsley Buttered Potatoes Summer Squash Crabapple Salad Jelly Roll • Beef Rice Soup Lamb Chop Macaroni and Cheese Pear Half-Raspberry Salad Pound Cake	**9** Grapefruit Half Crisp Bacon • Roast Beef Oven Browned Potatoes String Beans Banana Log Salad Peach Ice Cream • Tomato Soup Hamburger in a Bun Coleslaw Potato Frills Watermelon Cookies	**10** Orange Juice Egg Omelet With Jelly • Roast Lamb Lyonnaise Potatoes Small Whole Beets Pineapple-Strawberry Mint Salad Angel Food Cake • Cream of Mushroom Soup Cubed Beef Steak Buttered Noodles Sliced Tomato and Onion Salad Fig Bars	**11** Honeydew Melon Pork Sausage • Baked Ham Au Gratin Potatoes Cauliflower Carrot Sticks, Celery Curls Lemon Chiffon Pie • Chicken Soup Italian Spaghetti With Meat Sauce Italian Bread Tossed Salad White Cake	**12** Peach Nectar Soft Cooked Egg • Corned Beef With Chow Chow Parsley Buttered Potatoes Buttered Cabbage Pear-Lime Gelatin Salad Apple Turnover • Vegetable Soup Chicken Sandwich Cottage Cheese, Fruit Cocktail Salad Butterscotch Cookies
13 Grapefruit–Orange Slices French Toast • Roast Veal, Gravy Escalloped Potatoes French Cut Green Beans Peach Star Salad Strawberry Torte • Turkey Rice Soup Lamb Patty Diced Carrots Mixed Green Salad Baked Apple	**14** Tomato Juice Scrambled Eggs • Baked Salmon Lemon Buttered Potatoes Corn on the Cob Spiced Crabapple Salad French Apple Pie • Cream of Celery Soup Baked Macaroni and Cheese Lima Beans Fruit Gelatin Salad Angel Food Cake	**15** Cantaloupe Crisp Bacon • Roast Turkey Bread Stuffing Whipped Potatoes Asparagus Cranberry-Orange Salad Chiffon Cake • Alphabet Soup Frankfurter Baked Beans Coleslaw Fresh Peach Cookies	**16** Pear Nectar Pork Sausage • Roast Beef, Gravy Oven Browned Potatoes Buttered Peas Apple Waldorf Salad Peach Ice Cream • Split Pea Soup Creamed Ham on Rusk Baked Potato Deviled Egg Salad Sugar Cookies	**17** Pineapple Juice Poached Egg on Rusk • Meat Loaf, Mushroom Gravy Delmonico Potatoes Cauliflower Lettuce Wedge Napoleons • Cream of Asparagus Soup Broiled Lamb Chop Buttered Noodles Pear Half-Mint Jelly Salad Spiced Cake Squares	**18** Prune Juice Soft Cooked Egg • Broiler Baked Sweet Potatoes Buttered Green Beans Orange–Cranberry Salad Butterfly Cupcakes • Chicken Rice Soup Barbecued Beef on Bun Buttered Peas and Carrots Fresh Fruit Salad Baked Custard
19 Citrus Sections Scrambled Eggs • Roast Lamb, Mint Jelly Whipped Potatoes Stewed Tomatoes Melon Ball Salad Brownies • Consomme Bacon and Cheese Sandwich Asparagus Strips Complexion Salad Jelly Roll	**20** Fresh Peach Pork Sausage • Veal Fricassee Baked Potato Brussels Sprouts Deviled Egg Salad Apple Betty • Beef Rice Soup Meat Croquettes Creamed Macaroni Tomato Aspic Honeydew Melon Cookies	**21** Apricot Nectar French Toast • Baked Bluefish With Lemon Parslied Potatoes Harvard Beets Crisp Green Salad Pineapple Chiffon Pie • Oyster Stew Eggs Goldenrod on Rusk String Beans Pear-Cream Cheese, Grape Cluster Salad Puff Pastry	**22** Grapefruit Juice Poached Egg on Rusk • Ham a la King Steamed Rice Buttered Broccoli Cabbage, Carrot Slaw Cherry Cobbler • Mulligatawny Soup Open Face Hot Roast Beef Sandwich Whole Kernel Corn Molded Gelatin Salad Prune Whip	**23** Apple Juice Crisp Bacon • Roast Chicken Whipped Potatoes Wax Beans Cranberry Sauce Celery, Olives Peach Ice Cream • Bean Soup Salisbury Steak Baked Potato Cottage Cheese, Fruit Ring Salad Pound Cake	**24** Orange Soft Cooked Eggs • Corned Beef With Chow Chow Parslied Potatoes Buttered Cabbage Apple–Raisin Waldorf Salad White Cake • Beef Noodle Soup American Chop Suey Buttered Peas Lettuce Cup Watermelon
25 Kadota Figs Scrambled Eggs • Swiss Steak Paprika Potatoes Corn on the Cob Tossed Salad Strawberry Shortcake • Tomato Bouillon Liverwurst-Egg Salad on Rye Bread Creamed Macaroni Molded Fruit Gelatin Salad Baked Custard	**26** Pear Nectar Pork Sausage • Baked Ham, Raisin Sauce Au Gratin Potatoes Chopped Spinach Stuffed Peach-Pineapple Salad Apple Turnover • Split Pea Soup Chicken Chow Mein Steamed Rice Pear-Cranberry Relish Butterscotch Squares	**27** Stewed Prunes Poached Egg on Rusk • Calves Liver With Bacon Delmonico Potatoes Cauliflower Black Bing Cherry Gelatin Salad Blueberry Torte • Creole Soup Swedish Meat Balls Buttered Noodles Cabbage Slaw Chocolate Chip Cookies	**28** Blended Juice Soft Cooked Egg • Fillet of Haddock Parslied Potatoes Stewed Tomatoes Pineapple-Banana Salad Chocolate Cake • Corn Chowder Tuna, Noodle, Mushroom Casserole Buttered Carrots Deviled Egg Salad Cherry Tart	**29** Tomato Juice French Toast • Braised Beef Whipped Potatoes Buttered Asparagus Lettuce, Tomato, Pickle Salad Lemon Napoleon • Beef Barley Soup Lamb Patties Baked Potato Grapefruit-Orange Salad Raspberry Sherbet	**30** Banana Crisp Bacon • Turkey a la King Buttered Rice Green Peas Stuffed Celery, Olives Chocolate Ribbon Ice Cream Cookies • Chicken Rice Soup Sliced Ham Hot Potato Salad Peach Star Salad Strawberry Gelatin Pound Cake
31 Peach Nectar, Scrambled Egg • Roast Beef, Buttered Potatoes, Lima Beans, Raisin Waldorf Salad, Jelly Roll • Scotch Broth, Italian Spaghetti With Meat Sauce, Crisp Green Salad, Chocolate Brownies					

Ready-to-eat or cooked cereal served on all breakfast menus.



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What It Takes To Be a Good Engineer

Good maintenance parallels good management and the effective hospital engineer will know how to delegate and supervise as well as how to turn off valves

Daniel M. Roop

THE nature of hospital maintenance activities makes it impossible to perform necessary functions as smoothly as production activities are carried out in industry. Nevertheless, facilities can be maintained on a continual basis if the maintenance men have: (1) the right instructions, (2) the right materials, (3) the right mechanic, (4) the right tools, and (5) the right job at the right time.

Accomplishing all this, of course, presupposes proper investigation of any job. This is part of the preparation that implies there should be clarity in writing work orders, rapid and concise communications, thorough and systematic material expediting, and good timing through adequate scheduling.

Continual increases in labor and material costs are disturbing the financial balance of the hospital. Any possible source of saving is important. Where possible, maintenance costs must be reduced. Maintenance by itself is "unproductive," therefore it often suffers from indiscriminate cutting by so-called "meat axe" technics. Management often has a general disregard of the consequences of continual deferred maintenance, but enlightened management realizes the fallacy of such an attitude.

Nevertheless, our philosophy of hospital maintenance should parallel the philosophy of good business management.

Let us get a better understanding in our maintenance functions through realization by both management and maintenance teams of the effects of inflationary cost changes. It has been stated that in the last 10 years, during rising wages and higher costs of materials, maintenance expenditures have risen along with construction costs, approximately 7 per cent per year. However, in many phases of maintenance programs, costs have risen despite improvements that have been instituted by engineers and maintenance organizations.

As an example, a maintenance organization may have cut the per job man-hour usuage by 25 per cent, yet by the same token a 70 per cent dollar cost increase in a 10 year period may raise the dollar cost of this job 28 per cent higher than it was 10 years ago.

Encourage Brainstorming

This factor of economic life is often overlooked in maintenance evaluation by management, and thus a yardstick on the part of the maintenance people themselves is lost. If these economic facts are clarified and understood, considerable progress can be made in understanding maintenance procedures.

Other minor facts that should not be overlooked in hospital maintenance programs include the encouragement by management of "brainstorming" by our employes. Management should be patient, listen and be sincere in following through on employes' suggestions. Criticism from every source should be respected, complaints should be investigated, and answers should be given to patients and employes.

Apprentice training is essential for any maintenance organization. Courses taught by members of the maintenance staff can be provided, or attendance of night courses at local high schools, colleges or trade schools should be encouraged.

Every conceivable effort that is put forth by the hospital employe is affected, directly or indirectly, by good or indifferent hospital maintenance. It is worth while to "take stock" of ourselves in the light of our responsibilities; such an evaluation can help us all to do a better job.

Through constant appraisal, we should examine our operations for methods of improvement and increased operating efficiency. The method by which we approach any given task may adversely affect ourselves, the organization, and the patient.

For example, in one hospital a valve on a steam main serving the infant formula room sterilizer was shut off without notification to any of the staff. The sterilizer was manually operated, the cycle being timed by an independent clock. While the attendant was out of the room, the steam was shut off for 15 minutes. The attendant returned after 20 minutes, waited until the timer indicated complete sterilization, and then processed the formula. Within 24 hours a rash of dysentery broke out in the nursery. With proper communication between departments, this could not have happened.

Responsibility for operating policies should be delegated to qualified personnel. The chief maintenance engineer should have the responsibility of directing the preparation and mainte-

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Condensed from a speech presented at an area engineers conference, Veterans Administration Hospital, Dallas.

Mr. Roop is a hospital consulting engineer, Memphis, Tenn.

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nance of a hospital master plan, and checking on the sufficiency of the structures and all utilities. He should review requests and investigate the need for new construction to correlate with present plans, additions and alterations of existing facilities. He should also initiate action to prepare designs and estimates, reviewing them before he submits them to higher authority for approval.

It is helpful to examine methods of effecting improvements and increasing efficiency of operating policies. For example, are work methods up to date? Are power tools, paint rollers, and many other items of equipment that offer virtually noiseless, clean and efficient job performance used, in and out of patient areas?

Time and methods indirectly affect the patient by what may be termed hidden costs. Like hidden taxes, they are something that the patient has to pay for, although he seldom, personally, realizes their direct benefits.

Supervision and inspection may be accomplished by daily inspections, by reviewing the work of the maintenance and repair forces, and by noting their progress. Construction should be spot-checked for technical accuracy and compliance with engineering specifications and local and state building code requirements. Monthly meetings with sectional foremen or supervisors provide a means of supervising the administration of personnel relations.

Inspections Influence Attitudes

The direct interest and guidance of maintenance engineers, through daily inspections, will have an effect on the attitudes of employes toward their job and the importance of correct application of procedures. A few words of encouragement publicly, and of correction privately, will help promote confidence in employes and the job management is trying to accomplish.

Safety, fire protection and prevention programs should include frequent inspections to ensure safety training throughout the entire hospital.

The engineer should assist management in all phases of utilities and mechanical services in connection with the operation and maintenance of hospital buildings, equipment and grounds.

Department records and reports concerning use of utilities mentioned, as well as material and labor, should be maintained. Not enough engineers see their utility bills and are asked to approve them before payment.

Without proper analysis of the use of these vital elements, the maintenance department cannot render economical plant operation. Such records should also promote advantageous use of manpower and material.

Direction of the operation of heating, refrigeration, air conditioning, and so forth are vital services that are the engineer's responsibilities. How many maintenance engineers know the cost per patient day of engineering and maintenance operations relative to the services just mentioned? Without this knowledge they cannot effectively serve the patient. Only through proper records, knowledge and analysis of operating costs can the portion of the patient's bill that is a result of engineering and maintenance procedures be justified.

The maintenance engineer should interview prospective employes. He should make recommendations and coordinate with the personnel director.

The maintenance mechanic's contract with the patient, although not too frequent, can leave a lasting memory with the patient or the attending staff. Therefore employes must be chosen carefully. They should have instilled in them the need for a well groomed appearance and an understanding attitude toward other employes and the patient, whom, we must remember, is not himself when confined to a hospital room. Any adverse effect that a maintenance employe may convey to a nurse or doctor will set off a chain reaction that can affect the patient.

Timing a Factor in Schedules

The engineer should direct, prepare and assign schedules for the upkeep, repair and alteration of buildings, equipment and grounds, in accordance with established procedures. In the preparation and assignment of work schedules for these services timing, of course, must coincide with the availability of the areas under consideration.

In scheduling repairs it is also important to keep in mind interdepartmental services and their importance to patient care. Any unannounced disruption of another department's operations can cause a turmoil.

The appearance of the hospital grounds will not go unnoticed by patients. Neither will they usually forget interior appearances. The patient's impression can be formed by encounters with the many mechanical contrivances as well.

The engineer should direct and schedule a preventive maintenance program. Management should be the motivating factor if preventive maintenance is to be recognized like preventive medicine. A sound workable preventive maintenance program will offer the patient uninterrupted services as a result of continued operation of electrical, plumbing and mechanical plant facilities. Building maintenance will improve, resulting in a decrease in major repairs. Thus more maintenance man-hours can be spent in keeping plant and equipment in proper operating condition.

Be Prepared To Advise

The engineer may be called upon to give advice to the administrator or members of the administrative staff, including other department heads. Such advice concerning space requirements, typical plant needs, and equipment purchases should be approached both from a management point of view as well as from one of engineering economy.

The medical staff may request members of the engineering staff to aid in the development of new devices and equipment to help in the treatment of patients. Thoughtful and considerate advice to other department heads may eventually result in their being able to continue or even improve their services.

Assistance in the preparation of budgets for construction jobs as well as operating and maintenance budgets must be given continuously. In construction jobs beyond the scope of maintenance forces, or major alterations as recommended to administration, the maintenance department is responsible for the engagement of, or review of, outside contractors and for estimates of costs of repairs or new construction. The engineer should also review all plans and specifications and inspect the work as progress is made.

An expert has been defined as one who has all the answers, but who has never understood any of the questions. The engineer has an obligation not to fool himself into being an expert. ■

IS THERE TOO MUCH TALK ABOUT RESISTANT STAPH AND TOO LITTLE ACTION IN PREVENTING INFECTION?

Medical and hospital trade literature, the last few years, has been filled with articles and advertisements about resistant Staph. The problem has been serious. But we feel that resistant Staph is not the basic problem. It is the danger to patients from **all kinds** of infection. A workable patient-safety program is not an easy one to maintain.

A giant step toward the solution of this infection problem can be taken, we feel, by recreating the old-fashioned attitudes toward cleanliness in **all** hospital personnel in **every** department.

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The Hospital's Side of a Hospital Strike; a Case Study From Swedish Hospital, Seattle

(*Continued From Page* 68)
restaurant owned by one of the members of the Swedish Hospital board of trustees. Those present, in addition to myself, were:

Elmer J. Nordstrom, president of the hospital board

Dr. James Hunter, president of the hospital council

Dr. Robert Brown, vice president of the hospital council

Harry Carr, president of the King County Labor Council

Barney Mitchell, vice president of the King County Labor Council

James Estep, international representative of the Engineers Union

Eugene Hauck of the Auto Salesmen's Union (representing the joint council of teamsters).

The union representatives asserted at the outset that this was a friendly meeting aimed at finding a possible ending of the strike within a day or two. We agreed to eat dinner before beginning discussions. Mr. Hauck, who sat immediately on my left, then stated that he had another meeting and had no time to eat dinner, but that before leaving he wished to make a statement on behalf of the joint council of teamsters. He then proceeded to launch a vicious tirade at me personally, at which he accused us of several dastardly actions:

1. Deliberately loading up the hospital with patients in order to embarrass the striking union.

2. Deliberately falsifying the urgency of the fuel oil situation at the Swedish Hospital. He stated that he had affidavits to prove that we had ample oil for 10 days of operation (the facts were that at the time of this discussion we had enough oil for approximately 60 hours, several loads of oil had already been blocked, and the situation was becoming desperate).

Mr. Hauck permitted no refutation of his allegations, and his demeanor was so threatening that for the first time since the trouble began I seriously became afraid for the safety of my family. Mr. Hauck said to me, "Get this monkey off our back or else."

Despite the remonstrances of his colleagues, Mr. Hauck refused to stop talking until he had finished his attack. He then stood up, gave me a friendly pat on the shoulder and left the room. All of us were more or less stunned and even the other union men were unable to finish their dinner.

The president and vice president of the labor council then talked in a very friendly way, but the gist of their conversation was: "Come on fellows, be reasonable; this is a union town and when in Rome. . . . You'll find that dealing with the union isn't so bad." Our reply was along the lines that this particular union had proved impossible to deal with because its representatives had been dishonest with us throughout the negotiation and had demonstrated no concern whatever for the welfare of hospital patients.

We then pointed out that the union had consistently claimed from 125 to 130 employes of Swedish Hospital on strike, out of 200 eligibles. The actual count showed only 88 employes gone from the job out of 305 eligibles. We suggested that it might be well to hold an election to determine whether or not the union in fact did have a majority as it claimed. It was interesting to see how rapidly the union people "backed water" at this suggestion and said that a hospital was no place in which to have an election, and that the law did not provide for such. The meeting then broke up with many expressions of mutual esteem, but nothing whatever accomplished other than for each side to get a good look at the other side.

Were your suppliers affected by the strike?

On March 25, the dairy supplying the hospital received an anonymous telephone call in which the threat was made: "If you deliver milk to the Swedish Hospital tomorrow, you will likely find your driver stuffed in a garbage can."

Our meat dealer supplied us by the simple expedient of having meat brought up several times a day by people carrying two suitcases full of it. These people walked straight through the picket line and into the main entrance of the hospital as if they were patients coming in for admission.

On March 25, Mr. Hooper notified Station KMOTV that he had sent in two men disguised as hospital visitors for the purpose of counting patients in the hospital and that the hospital occupancy (which had been 368 on the night of March 19) had dropped to 130. (The actual occupancy on the date was 318 out of 372.) On the same day, although the pickets had consistently done everything to prevent supplies and fuel oil from reaching the hospital, Mr. Hare (Building Service international representative) informed the *Seattle Post Intelligencer* that they were taking additional measures to protect the patients of the hospital, and that they might have to take firmer measures in the strike.

What was the local medical society's position during the strike?

On March 25, the press carried a statement in which the King County Medical Society deplored the existence of the strike. We had pressed the officers of the society to come out with some such statement for what public relations value it might have, and although the statement was not so strong as we had hoped it would be, I think it did some good.

Was the quality of care affected by the strike?

On March 26, Mr. Hooper personally circulated a statement to the newspapers and television stations, in which he alleged that the Swedish Hospital was attempting to cope with a serious outbreak of staphylococcus infections. This document was so vicious that one TV news director informed Mr. Hooper he couldn't release the item because, although he carried libel insurance, he "didn't carry that much."

Within an hour or two after we had received a copy of the document, we countered by requesting the county health department to make an immediate formal inspection of the hospital. The health authorities cooperated by conducting an inspection on the same afternoon. They released a formal statement to the press in which they related they had found conditions in the Swedish Hospital, so far as patient care and general cleanliness and maintenance were concerned, substantially above the average for the community. This effectively killed any propaganda value the release might have had even if it had been actually publicized. (*Continued on Page* 126)

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(*Continued From Page* 124)

Was there any vandalism or threats of violence?

During the night of March 26, a number of "Unfair" signs were plastered around the building by several men including James Pritchett, who was subsequently identified as the business agent of the Window Washers Union.

Actual violence or terrorism included the following:

1. On many occasions during the night strings of firecrackers were ignited outside the hospital.

2. On several occasions firecrackers (in large bunches) were thrown from moving cars in the early morning hours outside the homes of the assistant administrator and several department heads, as well as my own.

3. On the evening of April 5 a stench bomb was thrown through an open window of the hospital, landing in the doctors' dining room. At the time this bomb was thrown Mr. Hare was present on the picket line.

4. Nails were scattered about the building in positions where they caused flat tires on the cars of visitors to the hospital.

5. At night "torpedoes," small explosive devices, were scattered where they detonated when people walked on them.

6. The nonunion maintenance men previously mentioned received threats and were advised "to get police protection" if they insisted on working at Swedish Hospital.

7. The engineers union threatened to pull the operating engineers off their jobs in any hospital in the city if the Swedish Hospital insisted on reopening its laundry. Their bluff was called on this and nothing happened.

8. The union leader, Mr. Hooper, arranged to have a flat tire on his car just opposite the hospital driveway in order to prevent delivery of oil by the hospital's own oil truck. An alert policeman insisted that he change the tire without delay, which he did in a driving rain, and completed his repairs just prior to the arrival of the oil truck.

9. Stones and steel balls were shot through windows at the hospital and in the student nurses' residence on several occasions.

10. A patient in the hospital reported that a small smoke bomb was placed under the hood of his car when it was parked across from the hospital.

11. A stench bomb was thrust through the main doors of the hospital into the lobby during the early evening.

12. My wife received telephone calls warning her about using the family car, and implying that a bomb would be placed in my car. The threat was confirmed by sources known to the police department who actually pursued it on the assumption that such an attempt would be made and kept me informed of developments.

The Battle of the Hacksaws

One aspect of the strike that must have pleased the local hardware dealers involved the intake cap of the oil tanks. This cap was padlocked by the hospital each night to prevent tampering with the oil supply. Each night, the padlock was mysteriously stuffed with paper so that it couldn't be unlocked. And each night, an additional padlock was placed on the cap, apparently by the pickets. This meant, of course, that each morning we had to saw off both our padlock and their padlock and put on a new one. We used up a lot of elbow grease and a lot of padlocks. And an awful lot of hacksaw blades.

On May 11, James Pritchett, the business agent of the Window Washers Union, who had been a picket captain and extremely active in the strike, was arrested and confessed to possessing stench bombs. He was sentenced to six months in the county jail, three months of which were suspended. During this time the strike came to an end and the union leaders publicly disavowed Mr. Pritchett, deploring his conduct. He was publicly fired from his union job. Immediately following his release from the county jail in August 1958 he was transferred to Portland, Ore., and given a business agent's job with the Building Service International Union in that area.

I remember rather vividly one of many conversations which I held during the course of the strike with Mr. Hare, who was in charge of the picket line.

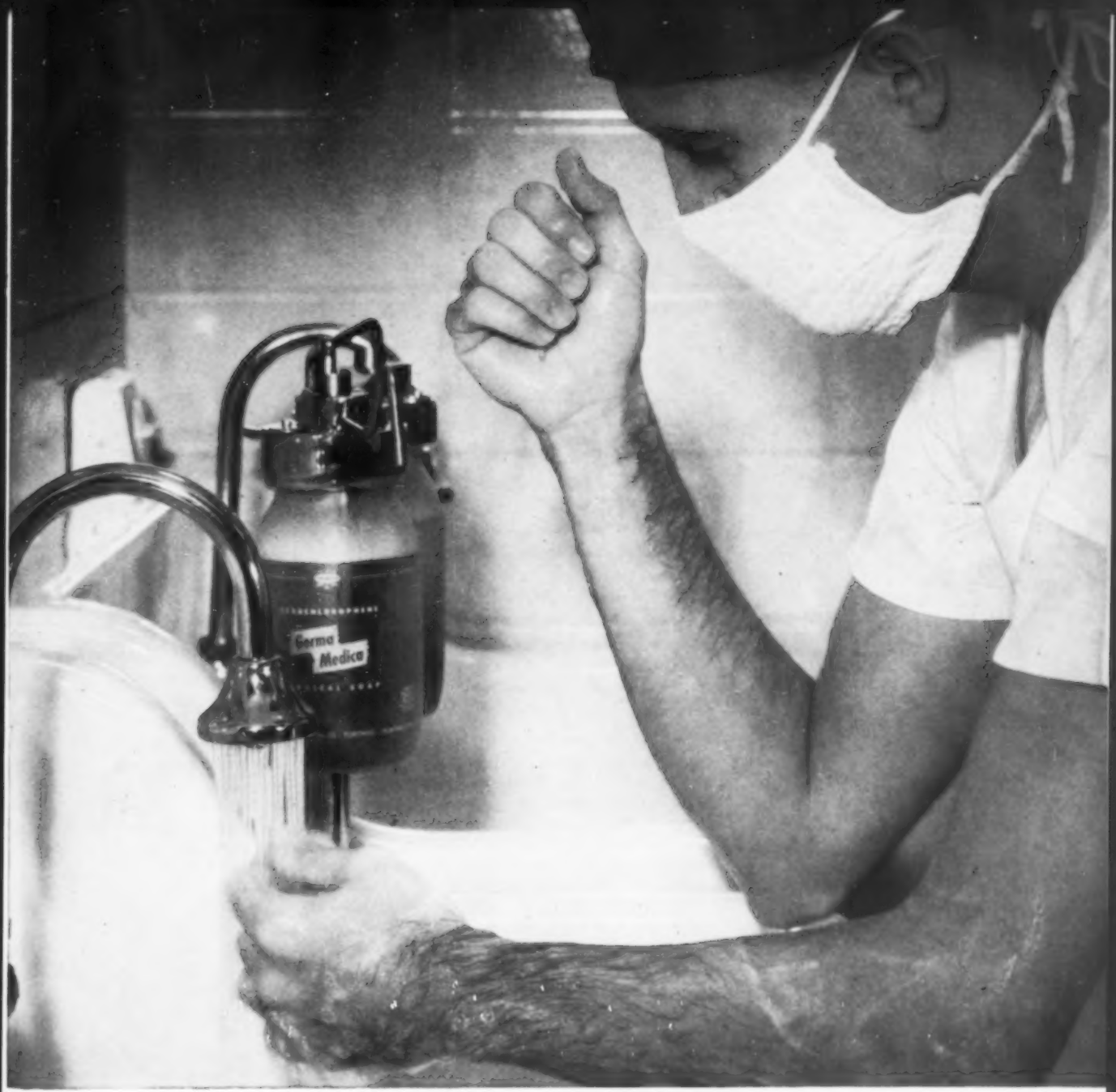
On this particular occasion nearing the fourth week of the strike after many episodes of violence had occurred, I asked Mr. Hare if he thought these tactics were going to do him any good, or if they were any credit to organized labor.

As usual he disclaimed any knowledge of or connection with the hoodlumism, and said that it was very embarrassing to him. He then said he wished we would be reasonable and sign a simple agreement with him because he was sure that the acts of violence would end if we would do so. I asked him what he meant by that, and he became embarrassed and said that what he meant was that he was sure the unknown persons who were taking advantage of the situation to perform these acts of vandalism would not want to continue them if the picket line were withdrawn.

At this point, Mr. Hare's attorney, who happened to be near by, rushed up and took him by the arm, walked him up the sidewalk a few feet, and proceeded to lecture to him quite vehemently. This incident was rather amusing to me, particularly since it occurred in the presence of a TV cameraman and his news editor. Up to this time the union had, of course, been disclaiming any knowledge of violent acts and had been deploring them as being done by someone in order to deliberately embarrass the union. In my interviews with the daily newspapers that afternoon, I was able to state that Mr. Hare had announced in the presence of witnesses that the vandalism would end if the Swedish Hospital would sign a contract with him. The public reaction to this could only be guessed, but I think it helped us quite a lot.

One more incident illustrates the duplicity of the professional union leadership.

During the last 10 days or so of the strike, some of us met almost daily in an attempt to work out a settlement. The conclusion of the strike was foregone by the men, and it was more a matter of trying to arrive at some kind of agreement which would enable the union to save a little face with its membership. We all knew what the outcome was, and, therefore, the discussions were conducted without bitterness. (*Cont. on Page* 128)



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After the meetings had been going on for more than a week, the union issued its newspaper in which it referred to "the employer's adamant refusal to deal honestly with a freely chosen bargaining agent of his employes," and said: "At no time has Swedish Hospital been disposed to deal in good faith; far from bringing about a settlement, these actions by the employer only tend to generate distrust and bitterness on both sides."

When I received this paper I called Mr. Hare immediately on the phone and pointed out that this was an extremely dishonest act on their part in view of the fact that he knew we had been negotiating almost daily in good faith in an attempt to get his people off the sidewalk and back to work.

His reply was: "Mr. Farwell, we take it for granted that employers know we have to say this kind of thing in order to keep our people in line — of course, we don't really mean it."

You mentioned difficulties with your oil supply. What happened?

Shortly after the strike began it became apparent that our regular fuel dealer, despite his previous assurances, could not be depended upon to continue fuel deliveries. This man, a large distributor for the Shell Oil Company, was obviously terrified by the various threats to his business and his safety which he reported he had received. We had, therefore, resorted to one of the common carriers in the area, who had brought us one large load, on the third or fourth day of the strike.

On the morning of March 28 at 1:30 a.m., a scheduled load was stopped by the picket line. Our fuel dealer called and advised that the teamsters union had told him no trucks could go to the Swedish Hospital without a court order. If the owner attempted to drive the truck himself, they would pull all teamster drivers out of his business and leave him without any means of supplying his other customers.

This was a crucial day in the strike. By 10 a.m., it was estimated that our fuel was sufficient to last approximately 48 hours longer, or until noon on Sunday. At 11 a.m., the hospital heat was reduced slightly to conserve fuel. In addition, all nonessential uses of steam in the building and in the nursing school building across the street were curtailed. Around 11 a.m., at the time fuel consumption was curtailed, an increase in the number of pickets was observed. (We later learned that the union members had been informed that this was the day that the hospital would be forced to capitulate for lack of fuel, and apparently they had assembled to witness the surrender.)

The Issue: To Recognize Or Not to Recognize

The strike at Swedish Hospital was strictly an organizational strike. Wages and working conditions were not even secondary issues. Swedish Hospital wage scales and fringe benefits equalled or exceeded those in other Seattle hospitals. Since the only issue was recognition, *i.e.* a contract giving the union bargaining rights, there was nothing to arbitrate or mediate. It was simply a matter of recognizing or not recognizing the union.

Although the union claimed a numerical majority, it had only 29 per cent of eligible employes off the job. By continuing to resist, the hospital protected the 71 per cent who wanted no part of the union.

In my opinion, many people seek work in hospitals in order to avoid union membership.

The attorney who was assisting us was then called. He arrived shortly before noon, and remained at the hospital until shortly before midnight.

During this time we investigated and followed one blind lead after another in a desperate attempt to obtain a load of fuel oil. A number of dealers or drivers said that all we had to do was ask and they would be glad to bring a load of oil to the hospital; however, none of them ever actually made it. Either they lost their courage or were threatened so drastically that they turned back before arriving.

Late in the afternoon a telegram was dispatched to one of the common carriers who had previously refused by telephone to undertake delivery of the load. The telegram read:

"This will confirm that you have been requested by our supplier, Olympic Diesel Fuel Company, to immediately pick up from Shell Oil Company, Seattle, either 5000 or 6500 gallons of fuel oil PS400 medium for delivery to us. It is our understanding that you have the necessary equipment to accomplish the delivery. Inasmuch as you hold yourself out as a common carrier under authority of the Washington Public Service Commission to perform their required service, we must demand that you do so forthwith; otherwise it will be necessary for us to take appropriate action against you."

This had the desired effect and around 7 p.m. a telephone call from the carrier stated that his superior in San Francisco had directed him to deliver the oil.

Had To Refuel From Street

The stipulation was made, however, that the truck would not cross the picket line, but that hospital executive personnel would have to couple an extra long hose to the truck, run it across the sidewalk and into the hospital fuel tanks. This was subsequently done with enough police protection to defend us from the massed pickets who menaced us throughout the operation.

This load of oil was ultimately delivered, but at this point we decided that we would somehow have to acquire trucks and handle our own oil. Later we did just that.

During the disputes over oil deliveries in the middle of the night I made a point of informing Mr. Hare that if he shut us down and patients died I would see to it that he got full credit. The way I put it was that I would immediately call the Associated Press and the other wire services and make a statement to the effect that the strike was being run by Arthur T. Hare, the international representative of the Building Service International Union and that he and his union would bear full responsibility for the death of any patients occurring as a result of the shutting down of the hospital power plant.

This did not have any visible effect on Mr. Hare. However, about an hour later the driver of the oil truck that was being blocked said, "Hare, I'm not trying to tell you how to run your business, and this is no concern of mine, but I don't think you can afford to stop this load of oil." Shortly thereafter

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Mr. Hare gave his permission for the load to be discharged into the hospital fuel tank.

On April 1 the hospital acquired its first oil truck, an old 1942 Ford with "one-horse" characteristics. This truck was provided on a temporary loan by our regular fuel dealer, who hinted that he could no longer have anything to do with us but his sympathy was with us and he hoped we could survive with this old truck.

Subsequently, we acquired another larger truck and by April 10 this phase of the battle had been won and our tanks were full, although it was necessary for us to switch from one major oil company to another.

Now that the strike is over, how would you change the hospital's labor policy?

Our policy has always been to attempt to meet prevailing wages for the same kind of jobs in other industry in this community, and to do so in concert with the other hospitals in the city. Wage scales are established on a citywide basis. I would not change either of these policies. The strike settlement agreement provided for establishing grievance machinery within each hospital, a mechanism which did not previously exist. Since that time we have set up such machinery, and it is known as the Employe Advisory Committee. Questions may be brought by individual employes to this committee. If satisfaction is not received, questions may be brought to the management. Ultimately the employe has the right of appeal to the Community Board of Appeals. This latter procedure is the only change in the hospital's labor policy, and I feel it is a good one.

Looking back would you do anything differently if you had it to do over again? If so, what?

I would insist on stronger and faster action by the local hospital council in officially supporting the struck hospital. Although this was consistently presented by us as a citywide problem and an action of the Seattle Hospital Council, and it had been agreed previously by the council that it would be so considered, I do not feel that this fact was sufficiently emphasized by group action or by adequate publicity from the hospital council.

The community in general considered that this was a strike of a union against the Swedish Hospital rather than against hospitals in general. The hospital council is presently studying a strong policy for group action.

Another thing I would do differently would be to be more decisive about eliminating union organizers from within the hospital building. In the pre-strike period we attempted to be tolerant, a sort of "live and let live" attitude, feeling that the union could not make very serious inroads since it really had no product to sell. The actual number of employes who went on strike (approximately 28 per cent of those eligible) indicates that although the union did not do too good a selling job, it did a better job than we had given it credit for. Looking back, I think we should have immediately insisted that any union organizers do their organizing somewhere other than in the hospital building.

So far as the conduct of the strike itself is concerned, although we had had no previous experience, I think we did pretty well. I don't know just how we could have conducted ourselves any differently and come out with a better result.

What do you think hospitals might do to defend themselves against such drives?

The first and most important thing that hospitals can do is to remove the incentive for employes to join an organizing drive, by convincing them that they are being fairly treated and that they have nothing to gain by such organization. Second, I think hospitals, either local or state groups, should keep the public well informed of what their position is and should continually stress the danger of union control in an institution dedicated to the care of the sick. Matters of life and death cannot be subject to the control of union business agents.

Hospital operation is too technical and too vital to be subject to the whims and the featherbedding practices which unions so frequently advocate. I would like to see hospitals in areas where it is practical (by that I mean in areas where they are geographically close enough to work closely together) develop some sort of mutual aid agreements whereby they come to each other's moral and physical support in the event of any strike threat. The strongest weapon of the union is the strike, and if this can be eliminated from the hospital field, organizing drives can be prevented or slowed down.

This should be done by other than legislative means because it has been pretty well established that, where strikes are prohibited by law, compulsory arbitration must be provided as a collateral "protection" of the workers. I think arbitration is pretty much a one-way street so far as union *versus* management is concerned. You will always lose something by arbitrating, and if you are forced by law to arbitrate over a period of time, you will be forced by law to yield one concession after another. To me the best answer is the development of a pact or agreement such as the Toledo Plan, or the Seattle Plan, which is patterned on the Toledo Plan. This provides freedom for the employes to join unions without fear of employer reprisals, but also provides absolute freedom of employes *not* to join unions. This to me is a basic American right. The thing about the Seattle Plan which I think justifies this sort of truce or immunity from union organization is that it provides an adequate substitute in the form of an opportunity for the employe through established channels to have his problems aired and his grievances solved.

Is there such a thing as a good union for hospitals?

Yes, I believe there is or can be. However, in my opinion this is limited strictly to the craft union rather than an industrial type of union. A good craft union can serve a useful purpose in providing skilled labor for technical jobs. It has no place in a hospital, however, unless it is willing permanently to forego the right to strike in a hospital. It must have responsible sober leadership, interested in the welfare of its members and interested in the welfare of hospitals and hospital patients. Its leadership must be well aware of hospital economic problems and hospital operating problems. This leadership must not be interested primarily in perpetuating itself and lining its own pockets. I think this automatically leaves out the majority of unions as constituted in our country today. ■

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V.A. Doctors Present Exhibit on Incidence of Reactions Following Blood Transfusions

ATLANTIC CITY.—The significant risk of blood transfusion was emphasized in a scientific exhibit presented at the annual meeting of the American Medical Association here last month. Drs. R. E. Peterson, R. L. Lawton and D. V. Walz of the Veterans Administration Hospital, Iowa City, Iowa, said the mortality from transfusion complications is comparable to the mortality rate of appendicitis or anesthesia complications.

It is estimated that between 2000 and 3000 fatal transfusion reactions occurred in the United States in 1956, they said.

Because of the possibility of transfusion reactions and complications, elective use of blood should be carefully analyzed in every instance, the authors stated.

"The term 'elective transfusion' is meant to cover the multiplicity of circumstances where indications for transfusion have not been conservatively evaluated," they said in a paper distributed at the exhibition. "This includes circumstances where the same therapeutic end could be accomplished much more safely by other means, as well as the use of transfusions as a tonic or for psychotherapy.

"The frequent practice of giving a single transfusion should be discouraged. The administration of only one pint of blood is rarely enough to be of any benefit, but may easily be enough to do serious harm. The risks of transfusion have usually been ignored in deciding upon the prescription."

The exhibition included graphs showing the percentage of obstetrical patients receiving transfusions in a single year in one group of hospitals. Hospital use varied from a fraction of 1 per cent to more than 12 per cent, the graphs indicated.

"The wide variation in transfusion usage carries implicit evidence that indications for transfusion were interpreted with considerable variation," the authors stated. "This type of information should permit hospital staff tissue committees to look at samples of their records and establish whether transfusion indications are being interpreted too loosely."

Even where positive indications for blood use are present, there are lapses in following standard procedures—occurring most commonly at night, when the laboratory is staffed with substitute personnel, it was pointed out. "There is evidence that a fair amount of blood is being administered without cross-matching and perhaps without typing," the authors said. They recommended the following standard procedure:

1. The cross-match should be checked by two qualified individuals.
2. Give the correct blood type to the correct patient; the recipient's name on the bottle and donor blood type should be checked to avoid the confusion of similar names.
3. Intravenous administration is as effective as intra-arterial administration.
4. Observe the patient carefully initially. It is always wise to give the first 50 ml. blood over a 30 minute period while under close scrutiny. Fatal transfusion reactions have occurred only when more than 300 ml. blood has been given.
5. The permissible universal donor is Type O with low anti-AB titer, with group specific susceptible additive.
6. Return outdated blood to distributors rather than permit its use for nonspecific cross-match transfusions.

ATLANTIC CITY.—Progressive patient care got a strong endorsement here last month when incoming A.M.A. President Louis M. Orr of Orlando, Fla., said in an address to the House of Delegates that the progressive care concept would improve patient care and permit construction and operating economies in hospitals.

Dr. Orr succeeded Dr. Gunnar Gundersen of LaCrosse, Wis., the retiring president. Dr. E. Vincent Askey, Los Angeles surgeon who has been speaker of the House of Delegates for the last several years, was named president-elect at the annual session.

In his address to the House, Dr. Orr said the A.M.A. should encourage development and increased use of rest homes, nursing homes, rehabilitation centers, chronic illness facilities, home care programs, homemaker services, and other facilities for patients who do not need complete hospital care.

"In the field of hospital costs, and this perhaps is the major problem in the over-all picture, the A.M.A. should draw attention to all new ideas on the organization, design and construction of hospitals," Dr. Orr said. "One of these is the concept known as 'progressive patient care' — which means the systematic classification of patients according to their medical needs.

"Under such a program the hospital can concentrate expensive equipment and highly skilled personnel in an intensive care unit for patients who need close attention. Then, as a patient improves, he can be moved to an intermediate care unit and finally to a convalescent or self-help unit. This will represent the concept of automation in patient care. This concept improves patient care and produces economy in construction and operating costs."

Dr. Orr also predicted that plastics would replace bricks, mortar, metal and plaster in the construction of hospital and medical facilities, and that adhesives will be substituted for nails and bolts.

"We will also see the increasing use of computing devices, which will assist in reducing costs," he concluded. "Moreover, because of the variation in room rates for the different units, the hotel aspects of hospitalization can be reduced."

In his final report to the House of Delegates, Dr. Gundersen said the physician's most important responsibility is to keep abreast of medical and scientific advancements.

"However, because of the current unmatched progress in medical science there must be an awareness and a willingness on the part of every physician that the need to keep abreast of medical advancements is his personal responsibility—to his patient, to himself, and to American medicine," Dr. Gundersen declared. "We must be ready to deliver 1959 medicine intelligently and with skill. Anything less, such as 10 or five year old medicine, will not do. Patients don't want 1949 or 1954 medical care. They desire up-to-the-minute medicine and they should get it. To me any physician who is not making an effort to keep abreast of medical knowledge blackens the eye of American medicine just as much as the individual who overcharges."

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NEWS DIGEST

Management Responsibilities, Procedures Discussed by Catholic Hospital Association . . . Hospital Labor Situation Described for Meeting of Middle Atlantic Assembly . . . More Universities Announce Administrative Residents

Management Responsibilities, Procedures Discussed by Catholic Hospital Association

ST. LOUIS.—The Rev. John Humensky, director of hospitals for the Cleveland diocese, was named president of the Catholic Hospital Association of the United States and Canada at the 44th annual convention here last month. The Rev. A. W. Jess, director of hospitals at Camden, N.J., was named president-elect. The Rt. Rev. Msgr. A. C. Dalton, Boston, was the retiring president.

More than 6000 religious and other workers in Catholic hospitals attended the convention here, the Rev. John J. Flanagan, executive director of the association, reported. "Management: A Sacred Trust" was the convention theme, and topics for discussion at general sessions and section meetings emphasized management procedures and adminstrative responsibilities.

One of management's chief responsibilities in the hospital is to reduce costs, and current research in hospital operations indicates economies can be achieved through automation, Dr. Mark S. Blumberg of the Stanford Research Institute said in one of the principal addresses presented.

For example, telemetering may be used to take temperatures, pulse and respiration rates, electrocardiograms and blood pressures, he said.

"Capital costs of hospitals may increase substantially, but this could be more than offset by reductions in operating expenses per unit of service if adequate labor saving devices are developed and widely introduced," Dr. Blumberg stated. Among other methods of economizing, he named the following:

1. Hospitals may work together more closely to achieve additional improvements in operating efficiency by smoothing out erratic work loads and assigning work forces as needed.

2. A larger component of the hospital work force may be made up of well trained, responsible technicians using labor saving devices to increase productivity and reliability.

3. Hospitals may become larger in size, with more combining of separate institutions to achieve this end; the larger size is needed to ensure availability of diverse services to all patients on an efficient basis.

4. More hospital services may be available on a 24 hour a day, seven day a week basis by employing machines to stand by instead of people.

5. There may be greater standardization of procedures, layout and training from hospital to hospital and ward to ward to permit temporary or "floating" employes to be used with a minimum of training.

6. Hospitals may provide manufacturers with more accurate specifications of equipment needs.

At a session on personnel administration — another of management's major responsibilities, James W. Stephan, professor of hospital administration at the University of Minnesota, said that hospital relations with organized labor must be based on mutual confidence and respect.

"Many of us are not dealing with organized labor," Mr. Stephan said. "Many of us do deal with organized labor. But we do see trends indicating that more and more hospitals will be dealing collectively with representatives of groups. We want to deal fairly as representatives of management."

Preceding the convention, the conference of Catholic Schools of Nursing passed a resolution reaffirming its support of a single accrediting agency for nursing schools within the National League for Nursing. The resolution also commended the League for "its willingness to explore with the American Hospital Association and other organizations areas of the accrediting program which might be improved."

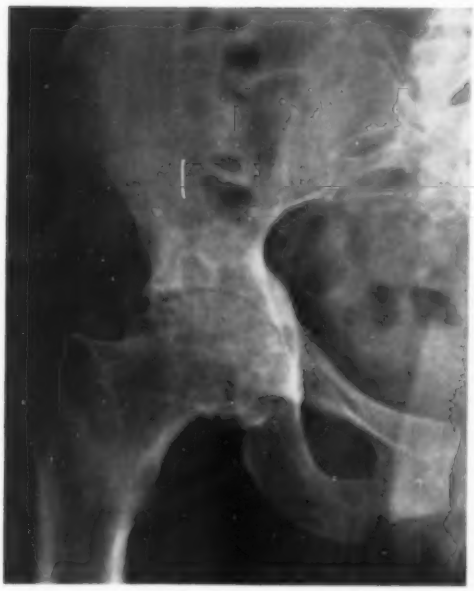
Hospital Labor Situation Described for Meeting of Middle Atlantic Assembly

ATLANTIC CITY.—Highlight of this year's Middle Atlantic Hospital Assembly meeting was a discussion on the labor situation as it affects hospitals, particularly those institutions involved in union demands in New York.

Hospital employe organizations in Minnesota were described by Donald E. Wood, executive director of the Twin City Regional Hospital Council, representing both Minneapolis and St. Paul hospitals, who stated that 27 of 30 hospitals in those cities have labor contracts. Permissive legislation, union interest, and substandard working conditions are ingredients that lead to collective bargaining, he pointed out. "Legal exemptions may not hold up in the long pull; do not count on them," he advised (see *p.* 73).

"Don't stand only on legal exemption; it may be quicksand," was the advice of Robert Doolan, attorney, Fellner & Rovins, New York. Mr. Doolan urged that each hospital analyze its own problems, conduct a personnel audit as an instrument by which to determine the standard of personnel practice to highlight vulnerable areas. Among items to be considered should be: minimum pay in relation to competitive jobs in other industries; policy of wage administration; wage ranges; justification for overtime work. The administrator should ask: How many satisfactory employes left because of wages? Does the "boss" receive report on practices and sum-

(*Continued on Page* 137)



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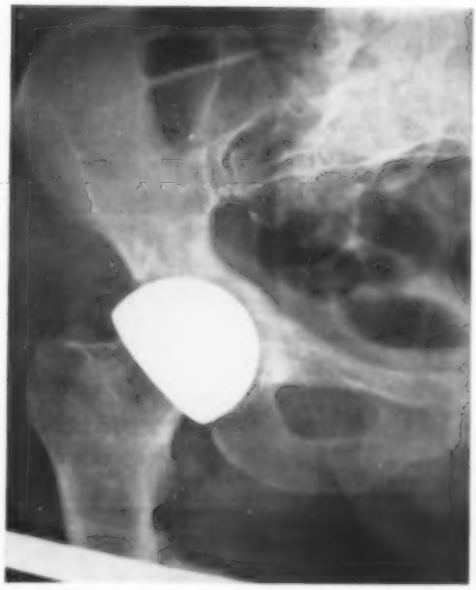

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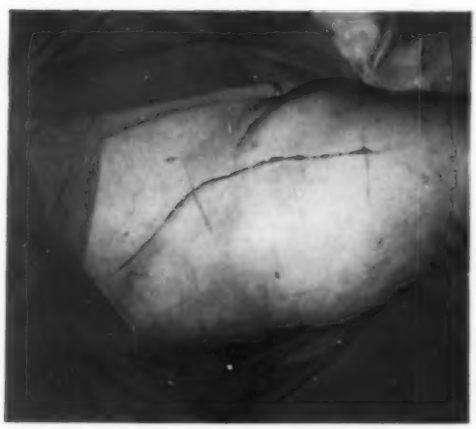

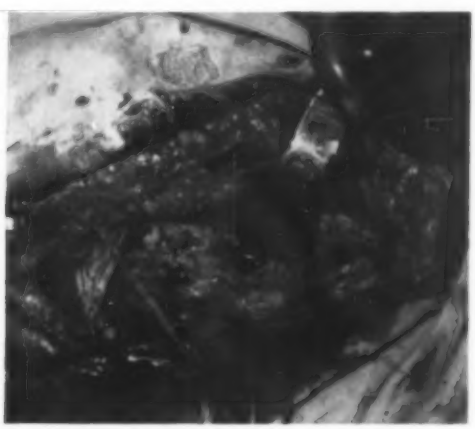

1. *(Illustration at left)* Anterior iliofemoral incision. Gloved hand is on medial side. **2.** *(Right)* Joint is now exposed. See how clearly color brings out the details: anterior capsule at bottom of wound; iliac crest at top; lateral femoral cutaneous nerve crossing below retractors.

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3. Capsule opened shows synovitis and irregularity of the osteocartilaginous junction of the head and neck.

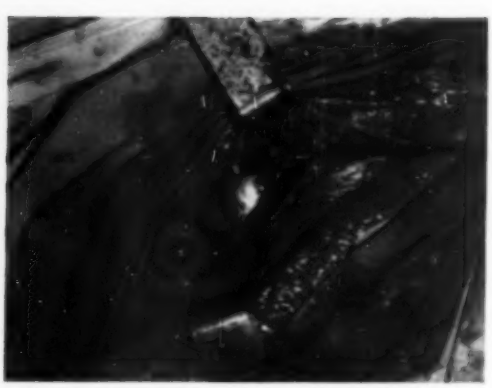
4. Head of femur has now been dislocated. Note erosion of cartilage in the acetabulum.

5. Acetabular reamer positioned for cleaning cartilage from acetabulum. *Here color differentiates textures.*

6. Head of femur is being cleaned of all sclerotic and cystic substandard bone and degenerated cartilage.

Check back over the illustrations on this and the preceding page: note their value as a teaching medium—today, tomorrow, years from now. A variety of Kodak color materials are available for your needs: Kodachrome Film for miniature and motion-picture cameras; Kodak Ektachrome Film and Kodak Ektacolor Film for sheet-film cameras; Kodak Ektachrome Film and Kodacolor Film for roll-film and miniature cameras. Kodak color print materials are also available.

7. Shows cup on head of femur.



8. Hip, reduced, back in position prior to closing incision.

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(*Continued From Page* 134)

mary of audit? Is the grievance procedure well defined and fair?

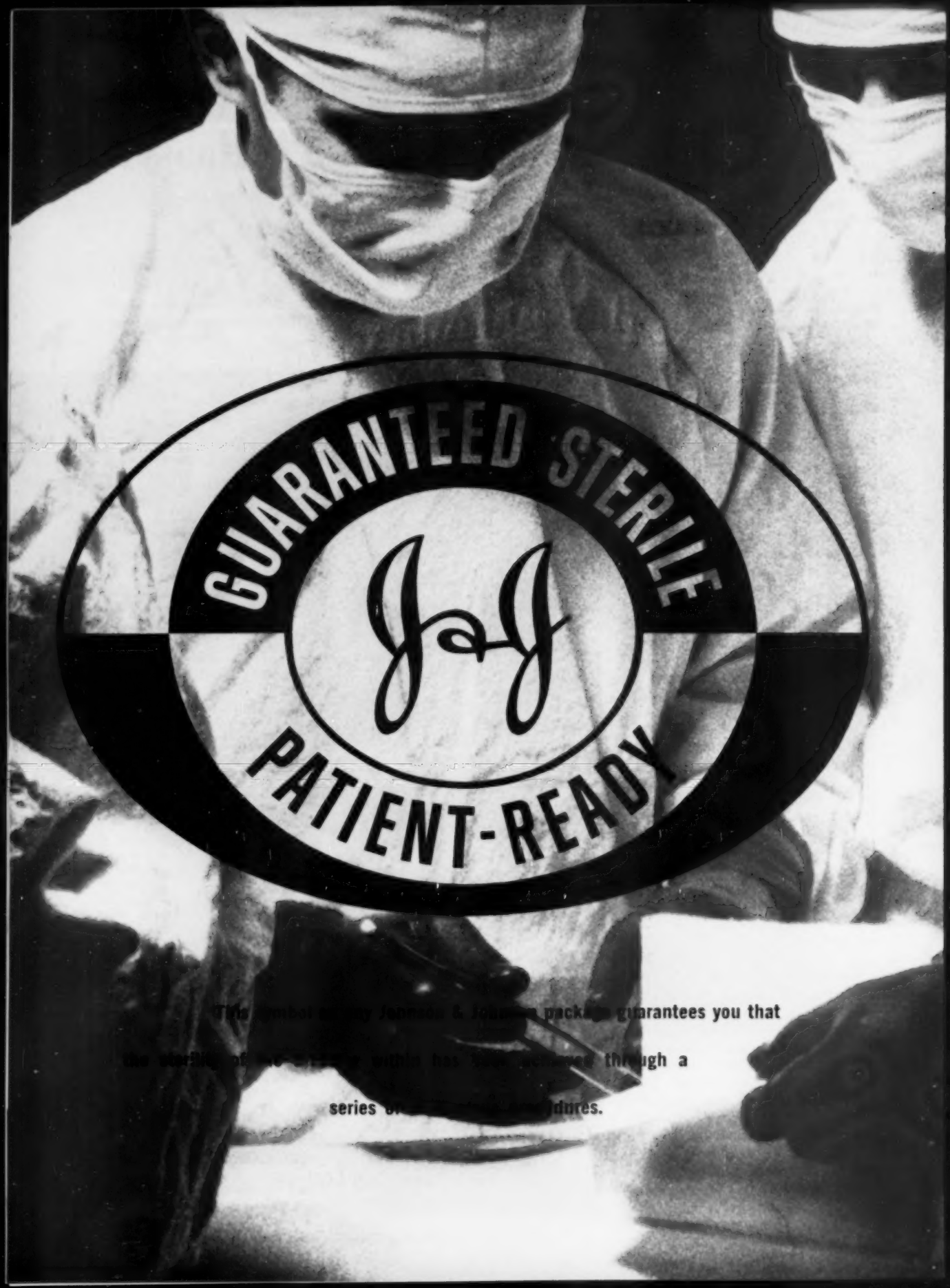
"A full-time personnel director is necessary if you have over 200 employes," he concluded (see *p.* 77).

The question of "whether specialized units are the answer to better patient care and lower costs" was presented and discussed by numerous participants, including Ralph M. Hueston, administrator, Chicago Wesley Memorial Hospital, Chicago. The Chicago experiment was discontinued, according to Mr. Hueston, because the intensive care unit on an average was only 67 per cent occupied. Attending doctors preferred to keep their patients on the regular services where they knew the nurses. Other speakers concurred with this feeling, citing as items on the debit side high quality staffing, the problem of passing on extra cost to patients, and the need for constant attendance by a doctor.

Charles G. Roswell, director of hospital services, United Hospital Fund, New York, said that as yet insufficient facts were available to determine the answers. For example, can capital costs involved in providing intensive care units be recovered through income? Also, how should the costs of the different services be determined and how should charges be based?

Renewed emphasis on the importance of establishing and maintaining good public attitudes was a feature of the presentation by Dr. Gerbart D. Wiebe of Elmo Roper and Associates, New York, on the survey conducted by that organization last year for the United Hospital Fund of New York. Dr. Wiebe stressed the importance of clarification of the different types of hospitals in the public's minds. "The patient," he asserted, "remembers the spoken word as it relates to his personal welfare, rather than the basic essentials of a hospital."

For the coming year, James C. Kirk, administrator, Pottsville Hospital, Pottsville, Pa., succeeds Dr. Ambrose P. Merrill, superintendent, St. Barnabas Hospital for Chronic Diseases, New York, as president of the Assembly, and David V. Carter, administrator, Fitken Memorial Hospital, Neptune, N.J., becomes vice president. John F. Worman, executive director, the Hospital Association of Pennsylvania, continues as treasurer, with J. Harold Johnston, executive director, New Jersey Hospital Association, as secretary.



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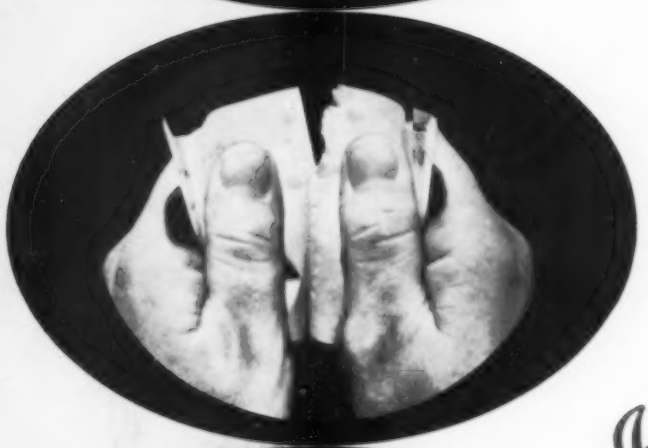

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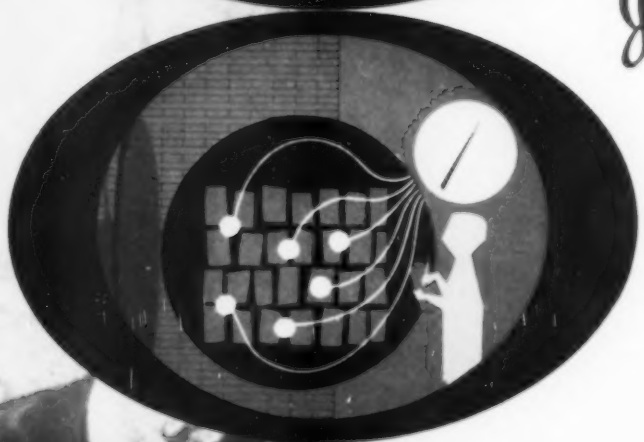

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State University of Iowa

University of Chicago

Universities of Iowa, Chicago Announce Student Administrative Residency Posts

IOWA CITY, IOWA.—Students in hospital administration at the State University of Iowa and their residency appointments are:

Capt. George F. Allen to Maxwell Air Force Base Hospital, Montgomery, Ala.; Richard H. Stenner to Methodist Hospital, St. Louis Park, Minn.; Howard A. Walker to Baptist Memorial Hospital, San Antonio, Tex.; John L. Garrett to Jackson Clinic, Madison, Wis.; Larry Pugh to St. Luke's Methodist Hospital, Cedar Rapids, Iowa; John P. Richwagen to Rhode Island Hospital, Providence, R.I.

Donald D. Washburn to Milwaukee County Hospital, Milwaukee; Dennis Q. Opheim to Trumbull Memorial Hospital, Warren, Ohio; Wilfred F. Loebig to Mercy Hospital, Council Bluffs, Iowa.

Jacque R. Larson to Morristown Memorial Hospital, Morristown, N.J.; Gerald R. Dokka to Schoitz Memorial Hospital, Waterloo, Iowa; Salvo A. Mundano to Veterans Administration Hospital, Burlington, Vt.; James E. Moon to District of Columbia General Hospital, Washington, D.C.

CHICAGO.—Hospital administration residencies as announced by the University of Chicago are as follows:

Benjamin G. Abramovice to Ohio State University Hospitals, Columbus; John W. Ayappa to Iowa Methodist Hospital, Des Moines; Barry T. Bedenkop to University Hospitals, Cleveland; Rosemary Capusan to Strong Memorial Hospital, Rochester, N.Y.; Robert A. DeVries to Miami Valley Hospital, Dayton, Ohio; Donald M. Furbush to Baylor University Hospital, Dallas; Dr. Sayed Hashmattullah to Alameda County Hospitals, Oakland, Calif.

Thomas R. Matherlee to Shannon West Texas Memorial Hospital, San Angelo; Gareth H. Mitchell to Baptist Memorial Hospital, Memphis, Tenn.; Haynes Rice Jr. to City Memorial Hospital, Winston-Salem, N.C.; Donald G. Shropshire to Eastern State Hospital, Lexington, Ky.; Peter Solyom Jr. to University of Chicago Clinics, Chicago; Harry A. Sugarman to Cuyahoga County Hospital, Cleveland; Clarence C. Traum to Presbyterian-St. Luke's Hospital, Chicago; Mary A. White to University of Indiana Medical Center.

Minnesota Students Assigned to Hospitals

MINNEAPOLIS.—Appointments of administrative residents in hospital administration have been announced by the University of Minnesota. They are:

Donald L. Bjorlin to Baylor University Hospitals, Dallas; David R. Branlsness to San Jose Hospital, San Jose, Calif.; Gaylord J. Bridge to St. Barnabas Hospital, Minneapolis; Capt. Emery E. Busch Jr. to Wright-Patterson Air Force Base Hospital, Dayton, Ohio; Robert E. Ernst to Bethesda Hospital, St. Paul.

Thomas J. Frawley to University of Wisconsin Hospital, Madison; Luther W. Goehring to Stormont-Vail Hospital, Topeka, Kan.; John R. Howard to Highland Hospital, Rochester, N.Y.; Charles F. Johnson to Menorah Medical Center, Kansas City, Mo.; Donald N. Johnson to St. Luke's Hospital, Milwaukee; Laurence E. Johnson to Rhode Island Hospital, Providence, R.I.

Harold M. Kelly to St. Luke's Hospital, Kansas City, Mo.; Robert J. Laur to Fairview Hospital, Minneapolis; Ernest W. Libman to Syracuse Memorial Hospital, Syracuse, N.Y.; Charles C. Lindstrom to Abbott Hospital, Minneapolis; John W. Luebs to University of Kansas Medical Center, Kansas City; Rufus W. Maderson to Johns Hopkins Hospital, Baltimore.

Lt. Victor H. Marcotte to Lackland Air Force Base Hospital, San Antonio, Tex.; Donald R. Olson to Presbyterian Hospital Center, Albuquerque, N.M.; Kenneth E. Omundson to U.C.L.A. Medical Center, Los Angeles; David R. Pesavento to St. Luke's Hospital, Duluth, Minn.

David S. Ridderheim Jr. to St. Luke's Hospital, Cleveland; Lyle E. Schroeder to Memorial Hospital, South Bend, Ind.; Kenneth T. Swanson to Swedish Hospital, Minneapolis; Dr. Eduardo L. Villegas to University of Minnesota Hospitals, Minneapolis.

Robert A. Vitello to Strong Memorial Hospital, Rochester, N.Y.; Paul J. Vogt to Charles T. Miller Hospital, St. Paul; John H. Westerman to University of Minnesota Hospitals, Minneapolis; Robert H. Wolter to Mt. Sinai Hospital, Minneapolis, and J. Warren Johnson to Baptist Christian Hospital, Tazpur, India.


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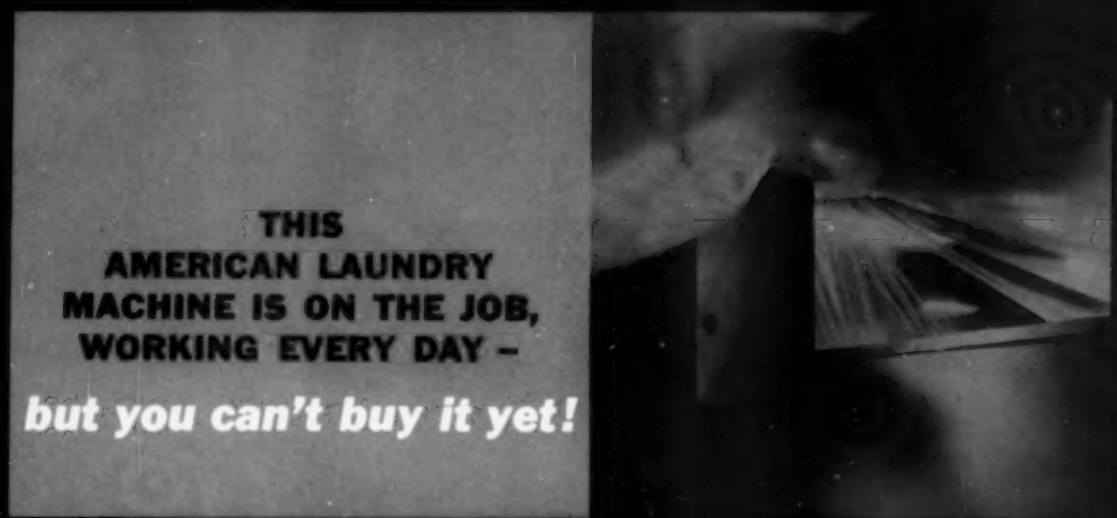

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New Film Shows How To Combat Infections

ATLANTIC CITY.—Methods of combating the spread of staphylococcal infection in hospitals were demonstrated in a motion picture shown for the first time to an audience of physicians and medical editors attending the annual convention of the American Medical Association here last month.

The half-hour color motion picture, "Hospital Sepsis, a Communicable Disease," was jointly sponsored by the A.M.A., the American College of Surgeons and the American Hospital Association. Dr. Carl W. Walter, associate clinical professor of surgery at Harvard Medical School, was medical adviser for the film, which was produced under a grant from Johnson & Johnson, New Brunswick, N.J.

The film presents an actual case history of hospital infection and, by means of animation and charts, shows how infection may spread through the hospital and suggests methods of preventing cross-infection.

The film was written and produced by Churchill-Wexler Film Productions, Hollywood, Calif. "One film cannot tell everything about hospital infections and what to do about them, but it can, and this one does, lay the groundwork upon which hospital administrators, physicians, nurses and all the rest can begin to construct a more detailed program of education," Dr. Dean Clark, chairman of the A.H.A. Committee on Infections, said in his introductory remarks at the film presentation.

Psychiatric Association Starts Architectural Service

WASHINGTON, D.C.—An architectural service has been established by the American Psychiatric Association to make available material collected in a five and a half year study of environmental requirements for psychiatric care, Dr. Mathew Ross, medical director of the association, has announced.

The consultation service will include planning, design and equipping of such facilities as public and private psychiatric hospitals, clinics, day hospitals, and residential units for children. Newer facilities, such as the night hospital, halfway houses, sheltered workshops, mental health centers, and special facilities for emotionally disturbed children and the aged, are also included, Dr. Ross said.

For additional information, use postcard facing Cover 3.

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Michigan Hospital Group Asks "Cost Plus" Formula for Blue Cross Payments

DETROIT. — A request that the existing Blue Cross payment formula be discontinued and a former "cost plus" method of payment be reinstated was approved by the house of delegates of the Michigan Hospital Association during the association's 40th annual convention here last month.

The request was made in the form of a resolution approved by the house of delegates recommending the change to the board of trustees of Michigan Blue Cross.

Commenting on the resolution, which was approved by a margin of 51 to 46 votes with only two-thirds of the members of the house of delegates present, a Blue Cross spokesman said there was a widespread misconception among Michigan hospitals that the existing payment formula puts a ceiling on Blue Cross payments to hospitals.

"This is not true," the Blue Cross statement said. "The formula simply puts a ceiling on the amount of increase in payments that will be made to any hospital, as related to the average increase for a group of hospitals of the same size and geographic location."

The resolution as approved by the delegates said that Blue Cross management, in applying the 1959 payment formula, "has not worked out the details of this program with respect to the variations in cost caused by variations in services and in quality of service and census."

The resolution recommended to Blue Cross trustees "that the present ceiling formula be removed as of Jan. 1, 1959, and that the payment formula revert to the 1957 formula of 102 per cent of cost or charges, whichever is lowest."

In separate resolutions, the house of delegates also recommended that the Michigan Hospital Association be empowered to nominate hospital administrator representatives to fill six additional Blue Cross trustee positions, and that Blue Cross adopt a ratification procedure for handling major changes in the plan's payment and benefit schedules.

Commenting on these resolutions, the Blue Cross spokesman pointed out that a majority of the Blue Cross board already is composed of hospital representatives, and that any changes in the payment formula, including adoption of the 1959 formula, "have been made with the advice and suggestions of committees composed of hospital people."

Dr. Roger B. Nelson, associate director of the University of Michigan Hospital, Ann Arbor, was named president-elect of the association during the convention. He will succeed A. Kent Schafer, Munson Hospital, Traverse City, who became president. George Cartmill, director of Harper Hospital, Detroit, was the retiring president.

"Lack of Business" Closes Contagious Disease Unit

BOSTON. — Lack of business is responsible for the closing of Haynes Memorial Hospital for Contagious Diseases, according to Dr. Chester Keefer, physician-in-chief of Massachusetts Memorial Hospitals, of which Haynes Memorial is a member.

When the hospital opened in 1908 the death rate in the nation from infectious diseases was 690 per hundred-thousand population, Dr. Keefer said. The figure has dropped to 80 deaths per hundred-thousand.

University of Michigan

University of Pittsburgh

Michigan Names Hospital Residency Appointments

ANN ARBOR, MICH.—Residency appointments as announced by the University of Michigan program in hospital administration follow:

Robert L. Flynn to Good Samaritan Hospital, Portland, Ore.; Garrett R. Graham to Saginaw General Hospital, Saginaw, Mich.; David E. Hoxie Jr. to University Hospital, Ann Arbor, Mich.; John J. Laverty to Henry Ford Hospital, Detroit; John B. Neff to Hartford Hospital, Hartford, Conn.

Albert R. Paulus to Children's Hospital of Michigan, Detroit; Chester E. Pearson to University Hospital, Ann Arbor, Mich.; Leonard R. Rymiszewski to Detroit Memorial Hospital, Detroit; John K. Springer to Mary Hitchcock Memorial Hospital, Hanover, N.H.

Joseph M. Stone to Evanston Hospital, Evanston, Ill.; Ronald N. Strand to Aultman Hospital, Canton, Ohio; Robert C. Templeton to U.S.A.F. Hospital, Wiesbaden, Germany; Robert P. Trautman to Blodgett Memorial Hospital, Grand Rapids, Mich.; Stuart A. Wesbury Jr. to Delaware Hospital, Wilmington.

University of Pittsburgh Announces Appointments

PITTSBURGH.—Students in hospital administration at the University of Pittsburgh have been appointed to the following residencies, the university has announced:

Lyle W. Byers to New England Medical Center, Boston; Edith Drobisevski to Thayer Hospital, Waterville, Me.; Capt. John A. Kelly to Carswell Air Force Base Hospital, Fort Worth, Tex.; Robert J. Maurer to Washington Hospital, Washington, Pa.; Thomas J. McKula to Cincinnati General Hospital, Cincinnati; Earl B. Raymer to Veterans Administration Hospital, Cleveland, and Barberton Citizens Hospital, Barberton, Ohio, and Edward P. Robinson to West Penn Hospital, Pittsburgh.

Grant To Start Course

CHICAGO.—The American Association of Medical Record Librarians has been granted $88,540 by the W. K. Kellogg Foundation to establish an extension-correspondence course for hospital employed medical record librarians, Doris Gleason, executive director of the association, announced June 12. Sara McKinnery, chief medical record librarian at University of Pennsylvania Hospital, Philadelphia, since 1954, has been named to direct the program.

Maine Hospital Association Hears Need for Secretary

ROCKLAND, ME.—The need to employ the services of an executive secretary to expand the work of the Maine Hospital Association was stressed by its retiring president, Matthew I. Barron, administrator, Portland City Hospital, at its annual meeting held here last month.

In another presentation, Richard T. Viguers, administrator, New England Center Hospital, Boston, said that if less time was spent by the executive head or leader in dwelling upon the failures of others, and greater thought given to his own deficiencies, better relations would result.

Mrs. Frances C. Austin, executive housekeeper, Concord Hospital, Concord, N.H., has her own answer to the problem of controlling staphylococcus infections. It is simple—plenty of soap, water and friction. Untrained housekeepers, she finds, can contribute to spreading germs throughout the hospital. For this reason she advocates proper training courses for these women, similar to those provided for doctors and nurses.

Hospitals are beginning to realize that patients have problems, too, according to Raymond P. Sloan, associate professor, school of administrative medicine, Columbia University, and chairman, editorial board, The MODERN HOSPITAL. "Research into the science of behavior," he declared, "has released new data on the dynamics of human personality and the emotional factors and social environments which tend to promote or prevent mental and physical disease. Through such studies hospitals are learning to move in 'teams' for patient care, thus helping not only those suffering from physical disabilities, but the emotionally distraught and the spiritually depleted."

Dolnar H. Littlefield, administrator, Augusta General Hospital, Augusta, Me., succeeds Mr. Barron as president, and John Barker, administrator, Maine Medical Center, Portland, becomes president-elect. Sister Mary Mercy, Mercy Hospital, Portland, continues as secretary, and Willard C. Mosher, Webber Hospital, Biddeford, Me., treasurer.

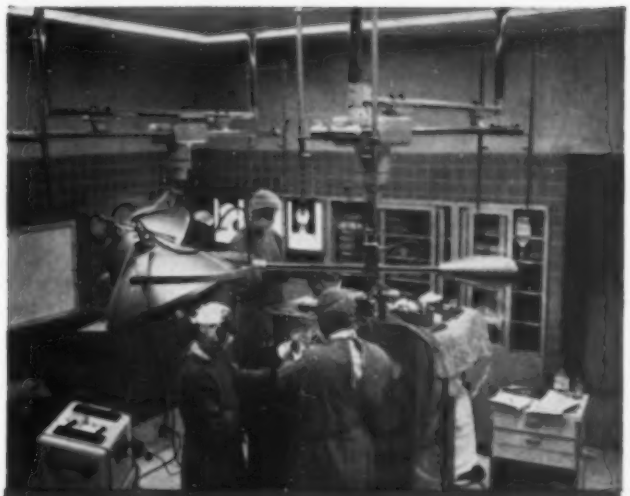
Practical Nurses Vote To Change Association Name

CINCINNATI.—The National Association for Practical Nurse Education has changed its name to National Association for Practical Nurse Education and Service. The change was voted by the more than a thousand delegates, representing the association's 23,000 members, at the organization's annual convention here recently.

The convention also passed a resolution to oppose duplication of the association's accreditation of schools of practical nursing, an activity now being contemplated also by the National League for Nursing. Another resolution approved the American Hospital Association's interest in establishing a joint accrediting service for schools of nursing and urged that N.A.P.N.E. be included in such a program in the area of practical nurse education.

Modern Hospital Index

The index to the last six issues of this year's magazines (January through June 1959, Vol. 92) has been printed separately. Send a note or post card for your complimentary copy. Persons who have asked for the previous index will be sent the latest index without further correspondence.



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Small Hospital Can Do Open Heart Surgery, Four Staff Members Say

CHICAGO. — Many small city and community hospitals could perform open heart surgery, generally done only in large medical centers, according to four staff members of smaller hospitals.

Writing in a recent issue of the *Journal of the American Medical Association*, they said there is no need for "an assemblage of a vast throng of superscientists" to accomplish heart surgery. All that is needed, the authors said, is "a trained surgeon and an interested and dedicated group of workers."

Neither need there be a "complex wilderness of gadgets" surrounding the heart patient. Small hospitals can provide the necessary equipment — mainly a mechanical heart-lung machine — and leave it to the large medical centers to obtain physiological data which require many expensive machines.

Each member of the operating team must be fully trained in his role in the operating room by repeated performance in the experimental laboratory, the authors said. The team should begin by performing the less difficult operations, such as those for repair of holes in the heart walls. Gradually they may add the more difficult procedures, such as the "blue baby operation."

The authors pointed out that there are at least 25,000 persons in the United States who annually are eligible for heart surgery. Many of these persons who otherwise could not receive treatment can be saved if open heart surgery is performed in small hospitals, they said.

"Foster Homes" Help V.A. Mental Patients

WASHINGTON. — Placement of recovering mental patients in foster homes is giving the Veterans Administration the equivalent of a 1500 bed mental hospital, the V.A. says.

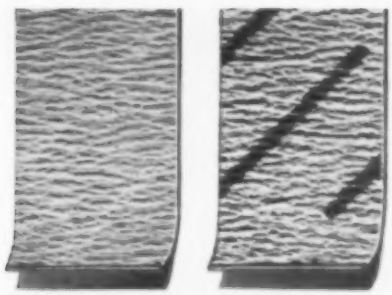
The agency's foster home program was started in 1951 to expand its psychiatric rehabilitation program, especially for those veterans hospitalized for a long period of time. It allows recovering mental patients to live in a home environment as a step in their return to the community.

The V.A. said that 1554 patients from its mental hospitals lived with "adopted" families in private homes near the hospitals during 1958, a 24 per cent increase over the 1249 in foster homes in 1959 and a 53 per cent increase over the 1011 in the homes during 1956.

The hospitals placed 807 patients in the homes during 1958 and reported 328 of those in the program had recovered sufficiently during the year to be discharged from hospital rolls.

Vote State Care Law

COLUMBIA, S.C.—Provision for a state fund to pay for hospital care of the categorically indigent has been signed into law here, making North Carolina eligible for federal matching funds on a 65 to 35 ratio. Previously, financing of care rendered to relief cases was considered to be the responsibility of the counties. The new law provides the necessary state matching funds by withholding 30 cents per capita from that portion of the state income tax proceeds that were previously returned to county governments for operating expenses.



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Most Cancer Patients Prefer To Know Truth, British Study Reveals

LONDON. — Two-thirds of patients suffering from curable cancer, out of a group of 231, preferred to be told the nature of their ailment, a study here has revealed.

The findings were published in the *British Medical Journal*, based on a study conducted at the Christie Cancer Hospital and Holt Radium Institute, Manchester.

In Britain, the report said, it is common practice for the physician to conceal the truth from patients suffering from cancer. As a result the only cancers which are known are uncured or untreated ones. As a result, the authors said, there is general ignorance of the possibility of cure.

Interviews with 93 men and 138 women after they had received a diagnosis of curable cancer revealed four general types of reactions: 153 patients were glad they had been told the truth; 17, all women, were sorry; 17 were unwilling to give a definite opinion, and 44 denied that they had been told the nature of their illness, a reaction found among more men than women, the study report said.

Those who approved of having been told asserted that it helped them face the treatment or that they felt more confident, and that ignorance would have worried them much more. On the other hand, most of them added that they thought only those patients whose condition is curable should be told the truth.

The group of patients who denied having been told, the authors suggest, may have been trying to forget what was an unpleasant shock, or may have been denying the truth to themselves. Some of the patients who regretted being told the truth mentioned the dismal associations of the word cancer.

Connecticut Group Elects

NORWALK, CONN.—Richard O. West, administrator of Norwalk Hospital here, has been named president-elect of the Connecticut Hospital Association. The new president is Charles T. Treadway, president of Bristol Hospital, Bristol, who succeeds Robert Kniffen, administrator of New Britain Hospital, New Britain. Elected treasurer was William G. Boies, member of the governing board at Waterbury Hospital, Waterbury.

NATCO splayed base prevents wall damage

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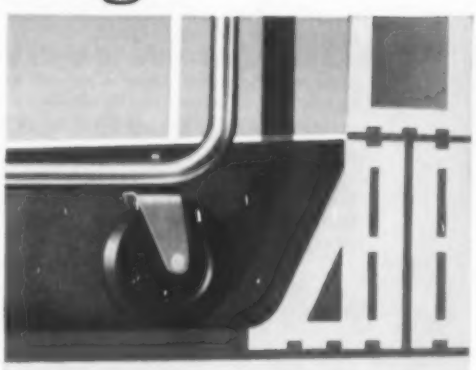

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COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Radisson Hotel, Minneapolis, Oct. 12-15.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Convention and Annual Meeting, New York, Aug. 23-26.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, National Institute, Statler Hotel, Los Angeles, Oct. 25.

AMERICAN DIETETIC ASSOCIATION, Shrine Auditorium, Los Angeles, Aug. 25-28.

AMERICAN HOSPITAL ASSOCIATION, The Coliseum, New York, Aug. 24-27.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Los Angeles, Oct. 25-28.

ARIZONA HOSPITAL ASSOCIATION, Monte Vista Hotel, Flagstaff, Oct. 8, 9.

COLORADO HOSPITAL ASSOCIATION, The Antler's Hotel, Colorado Springs, Oct. 8, 9.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 1.

IDAHO HOSPITAL ASSOCIATION, Elks Lodge, Boise, Oct. 19, 20.

MARYLAND-D.C.-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D. C., Oct. 26-28.

MEDICAL RECORD LIBRARIANS SCHOOL, University of Colorado, Boulder, Aug. 9-14.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, Oct. 7-9.

NATIONAL REHABILITATION ASSOCIATION, Boston, Oct. 26-28.

OREGON ASSOCIATION OF HOSPITALS, Coos Bay, Oct. 19, 20.

SASKATCHEWAN HOSPITAL ASSOCIATION, Bessborough Hotel, Saskatoon, Oct. 14-16.

1960

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, April 27-29.

Form Medical Center

NEW HAVEN, CONN.—Yale School of Medicine and the Grace-New Haven Community Hospital, affiliated with each other since 1826, have announced formal incorporation of the Yale-New Haven Medical Center, which began informal operation five years ago. Charles S. Gage, treasurer of Yale University, was elected first president of the medical center.

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N.Y. Taxpayers To Bear More of Increased Costs, Hospital Study Reveals

NEW YORK. — An increase in hospital costs, with a larger part to be borne by the taxpayers, was predicted by the Hospital Council of Greater New York following a preliminary study of municipal and voluntary hospital systems in the city. The survey is expected to be completed next fall, the council said.

"Because hospital care in this city is characterized by a liberal tradition of free or part-pay care, tax funds and philanthropy account for a larger fraction of total expenditures for hospital care in New York City than in the rest of the country. Although philanthropic support has increased in amount during the postwar period, it has not been able to maintain its relative share because of the marked increase in hospital costs," announced Dr. Hayden C. Nicholson, executive director of the council.

The increase in hospital insurance has been associated with an increase in the number of semiprivate patients and a gradual decline in the number of ward patients, the study revealed, but a significant proportion of patients with hospital insurance continue to receive care in the wards.

The council noted that little is known of the reasons why certain patients with hospital care insurance use the wards. Another study by the council had shown that hospitalization insurance covers 71 per cent of the city's residents. This is the same proportion as for the country as a whole, but not so high as for other urban areas, the council noted.

The decline in the number of ward beds has occurred only in the voluntary hospitals, the findings showed, while the number of general care beds and patients in the municipal hospitals remained constant.

The council attributed an increase in the number of semiprivate beds in the voluntary hospitals partly to a response to demand and partly to a desire to reduce the deficit incurred in caring for public charge patients.

In its study, the Hospital Council recognized that in the course of time a rough division had evolved between the voluntary and municipal hospitals, Dr. Nicholson said. The central problem today, the council believes, is the lack of a clear definition of the respective roles and proper responsibilities of the two groups of hospitals in meeting current and future health needs. Therefore, the specific objectives given for the study are twofold: (1) to ascertain the facts of the existing relations between the two groups of hospitals, and (2) to define the optimum conditions under which the groups of hospitals can jointly continue to serve the community most effectively.

New York Approves Four Blue Cross Rate Rises

NEW YORK.—Rate increases for four Upstate New York Blue Cross plans were announced recently by Thomas Thacher, state superintendent of insurance. Increases range from 28.8 to 43.3 per cent.

Plans affected are those in Buffalo, Rochester, Syracuse and Utica. In addition to the basic contracts to which the increases apply, the four plans also propose to offer alternate contracts with narrower benefits at lower rates, Mr. Thacher said. These alternate plans are under review by the state insurance department.

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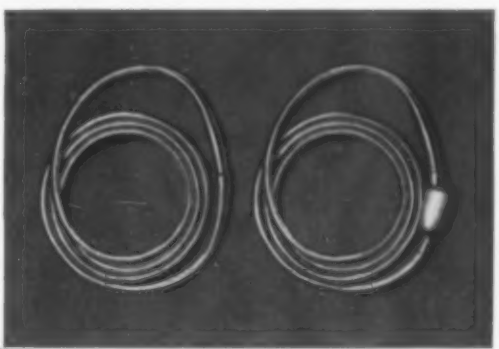
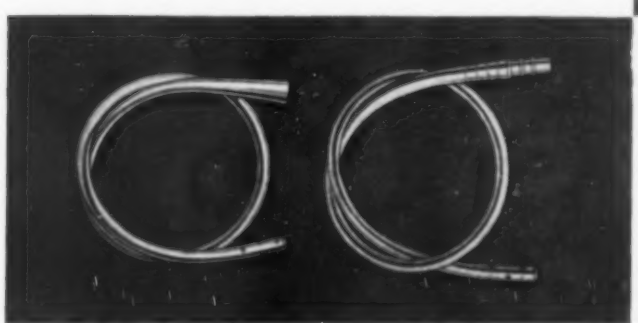
For Closed System—Davol Urine Drain Tube with Adapter Cap. 3/16 or 9/32 I.D. Tube with latex adapter to fit over neck of drainage bottle for closed system. Caps have vent holes to prevent vacuum and insure constant fluid flow.





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New Western Officers

New officers of the Association of Western Hospitals are: (front row, l. to r.) Ray Woodham, vice president, Presbyterian Hospital Center, Roswell, N.M.; Clifton H. Linville, treasurer, Fresno Community Hospital, Fresno, Calif.; (back, l. to r.) John Zenger, vice president, Utah Valley Hospital, Provo; Wesley G. Lamer, president, Physicians and Surgeons Hospital, Portland, Ore.; and Clyde W. Fox, the new president-elect, Washoe Medical Center, Reno, Nev.

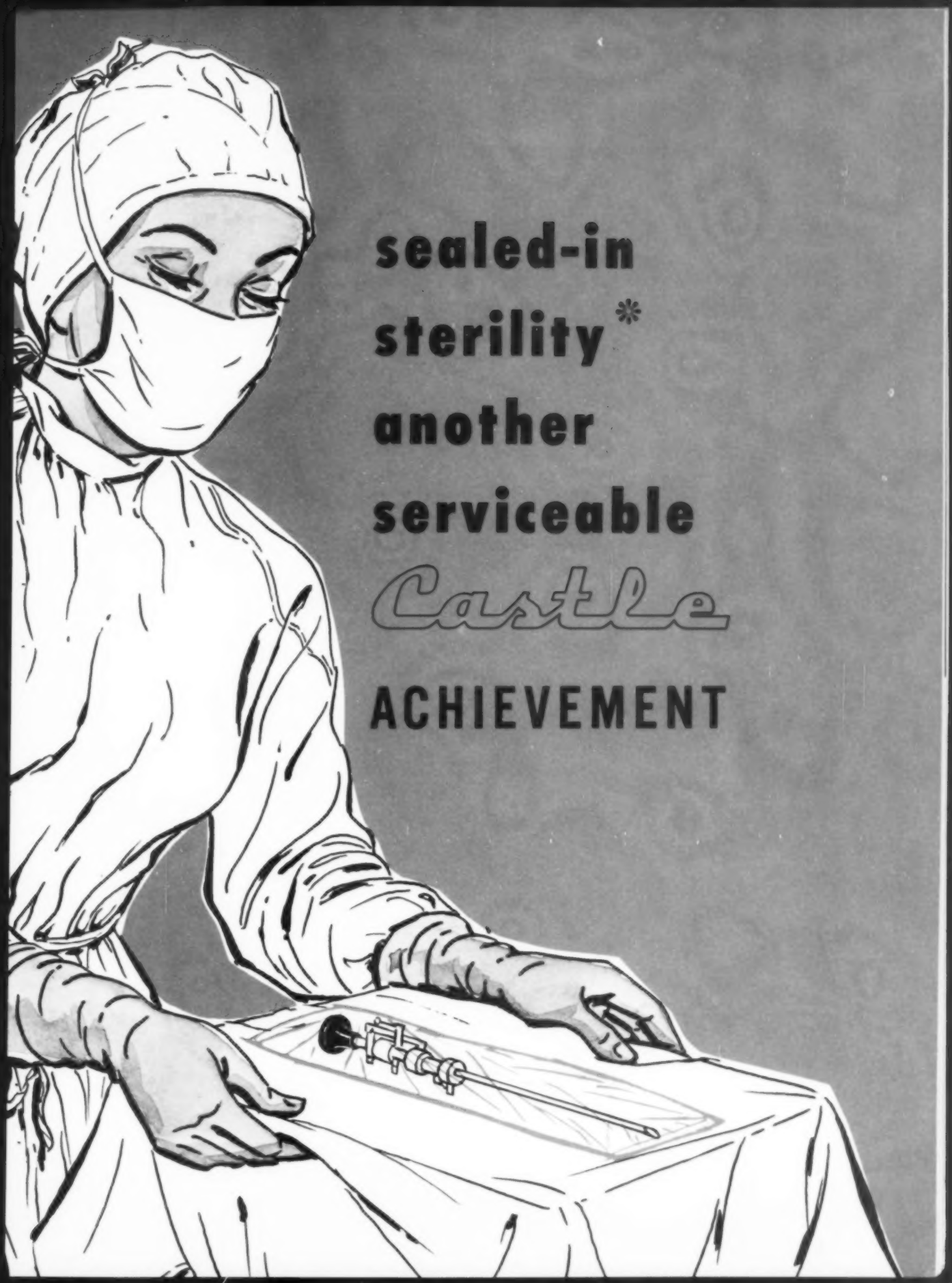
Form Provided To Report All New Polio Admissions

NEW YORK. — The National Foundation has provided for reporting of all new polio admissions on Form 609A (Notice of Admission or Readmission of Poliomyelitis Patient), the foundation has announced.

The form, which may be obtained from state representatives of the National Foundation, should be used to report all polio admissions, whether or not the National Foundation chapter is asked to provide financial assistance. Officials of the foundation and the U.S. Public Health Service said they believe use of the form can increase the speed with which potential polio epidemics can be spotted.

Awards Largest Contract

BETHESDA, MD.—The Public Health Service has awarded a $1,437,172 contract to the Sloan-Kettering Institute for Cancer Research, New York, for studies of new drugs for the treatment of cancer. The one-year agreement is the largest ever signed by the Service's Cancer Chemotherapy National Service Center here, the P.H.S. announced.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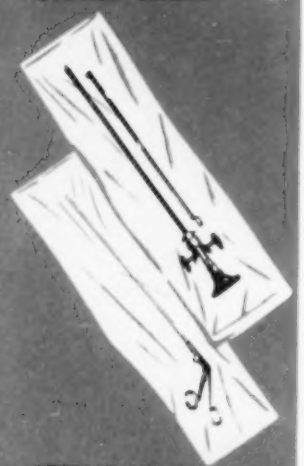

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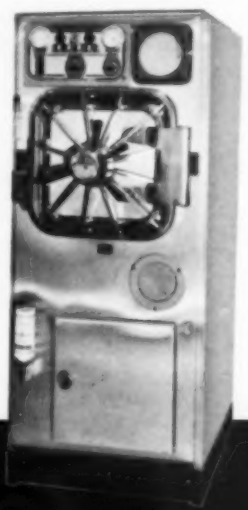
Another serviceable achievement made possible by the Castle Sterox-o-matic System —first gas sterilizing system developed for hospitals.



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Army Medical School Lists Appointments for Administration Students

FORT SAM HOUSTON, TEX.—Members of the 1959 class in hospital administration at the army medical service school, Brooke Army Medical Center, have been assigned to administrative residencies, as follows:

Maj. Raymond K. Mortensen to Madigan Army Hospital, Tacoma, Wash.; Maj. Philip L. LaManche to France; Capt. Maurice G. Winstead to Carswell Air Force Base Hospital, Fort Worth, Tex.; Maj. Walter P. McHugh to Lackland Air Force Base Hospital, San Antonio, Tex.; Lt. Col. Frank D. Godwin to Panama.

Maj. William P. Chambers to U.S. Army Medical Service Historical Unit at Walter Reed Army Medical Center, Washington, D.C.; Lt. Col. Frank K. Lawford to Germany; Maj. Martin Zachar Jr. to Letterman Army Hospital, Presidio, San Francisco; Capt. Aaron Ryan to Walter Reed Army Hospital, Washington, D.C.; Capt. Hazel L. Green Jr. to Valley Forge Army Hospital, Phoenixville, Pa.; Lt. Col. Eugene T. Brown to Brooke Army Hospital, San Antonio, Tex.

Lt. Col. Floyd L. Berry to Fitzsimons Army Hospital, Denver; Capt. Michael D. Guerin Jr. to Lackland Air Force Base Hospital, San Antonio, Tex.; Col. Pradist Tuchinda (from Thailand); Capt. William B. Neubrand to Wright-Patterson Air Force Base Hospital, Dayton, Ohio; Maj. Henry J. Rockstroh to Brooke Army Hospital, San Antonio; Maj. Carroll E. Clutter to Korea.

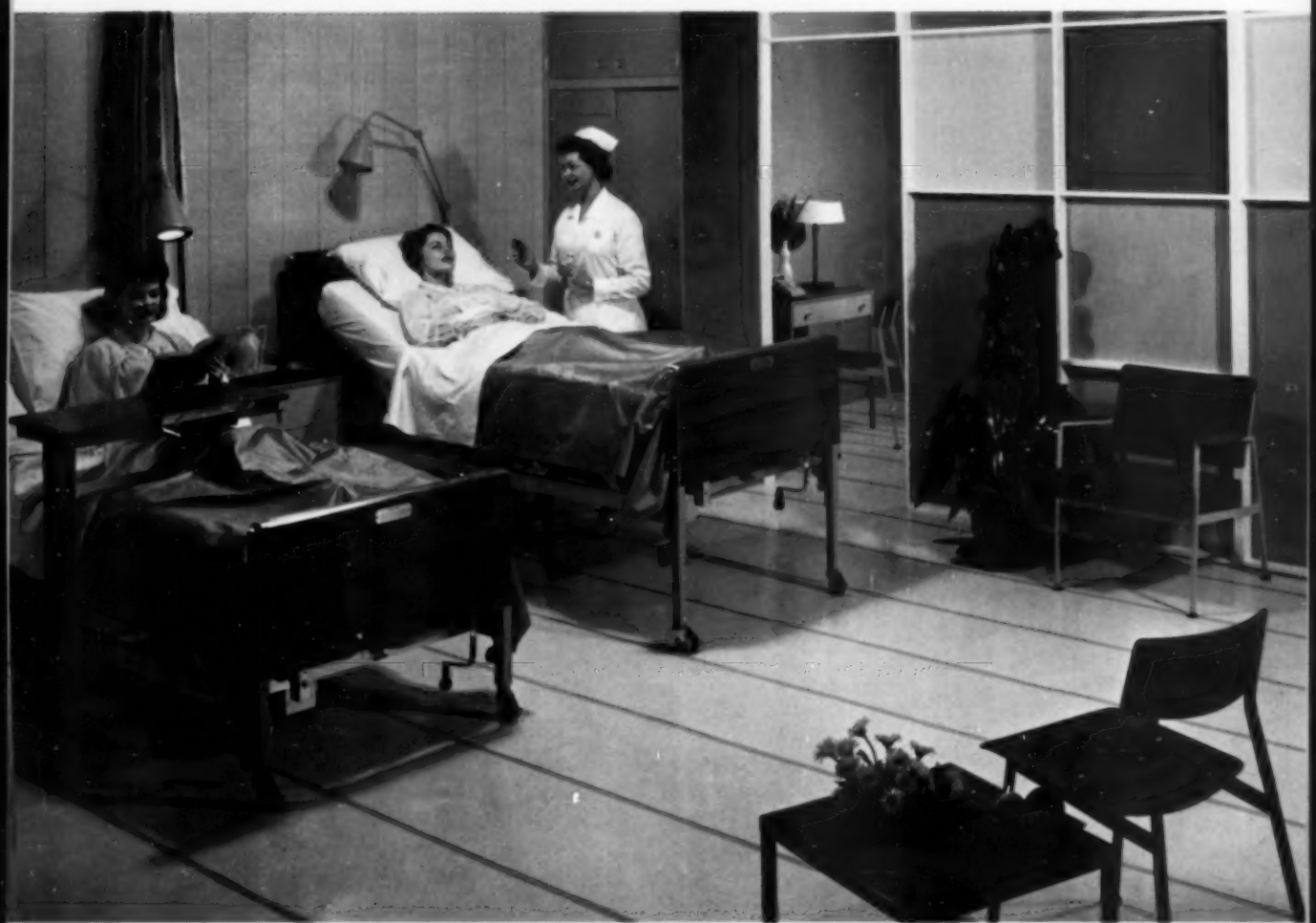
Capt. Alan Harcus to Letterman Army Hospital, San Francisco; Maj. Paul H. Myers to William Beaumont Army Hospital, El Paso, Tex.; Capt. Adam E. Adams to Valley Forge Army Hospital, Phoenixville, Pa.; 1st Lt. David B. Illsley to Chanute Air Force Base Hospital, Rantoul, Ill.; Capt. Donald B. Wagner to McDill Air Force Base Hospital, Fla.; 1st Lt. Alfred C. Schiefer to Keesler Air Force Base Hospital, Biloxi, Miss.; Maj. Howard T. Cohen to Brooke Army Hospital, San Antonio, Tex.; Maj. Jung Sukhyun (from Korea).

Lt. Col. Hamaoka Sunao (from Japan); Maj. Herman C. Needles to Walter Reed Army Hospital, Washington, D.C.; Maj Shoja Hejazi (from Iran); Maj. Arthur W Barker to Germany; Lt. Col. A. G. Sheikh (from Pakistan); Lt. Col. Robena C. Anderson to U.S. Army Hospital, Fort Hood, Tex.; Capt. Barbara L. Kennon to Walter Reed Army Hospital, Washington, D.C.

Maj. Lillian Dunlap to Fitzsimons Army Hospital, Denver; Maj. Althea E. Williams to Germany; Maj. Miyasaki Toschio (from Japan); Capt. Ray E. Van Cleave to Carswell Air Force Base Hospital, Fort Worth, Tex.; Maj. Mario Tapia-Caballero (from Chile); Lt. Col. James B. Miller to Madigan Army Hospital, Tacoma, Wash.; Lt. Col. Mohammad A. Khalaf (from Jordan); Col. Glenn J. Collins to U.S. Army Hospital, Ft. Leonard Wood, Mo.; Col. William O. Hastings to Brooke Army Medical Center; Maj. John J. H. Conners (from Canada).

NEW FROM SIMMONS

Twosome in Sunny Teak



See what a cheerful glow the new teak finish adds to these two Simmons motorized Vari-Hite beds—to the occasional chair and table, too. Here is the way to add friendliness and charm to a semi-private room, or to *any* patient's room.

The Vari-Hite beds themselves are marvels of utility. A flick of a switch raises or lowers them gently, quietly, safely. The graceful chairs and tables are Simmons Slimline design, hiding the strength and sturdiness of steel under their easy-to-clean finish. And behind the nurse, there's a space-saving Simmons built-in wardrobe—a new addition to the Simmons hospital line.

Simmons hospital furniture brings your hospital the beauty and prestige of topnotch design—and, as always, the almost indestructible durability, quality and ease of maintenance which have made Simmons famous. Styled by Raymond Spilman, A.S.I.D.

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Hospital Administrative Residencies for Northwestern University Students Announced

CHICAGO.—Northwestern University has announced the following residency appointments for students in hospital administration:

Capt. Masao Amano to Scott Air Force Base Hospital, Belleville, Ill.; Edward Bartz to St. Mary-Corwin Hospital, Pueblo, Colo.; Francis J. Blaise to St. Luke's Memorial Hospital, Racine, Wis.; Robert C. Boyd to South Carolina State Hospital, Columbia; Jack B. Carter to Ravenswood Hospital, Chicago.

John M. Cole to Southern Baptist Hospital, New Orleans; Charles K. Cooke to Grace Hospital, Detroit; William D. Currie to Keesler Air Force Base Hospital, Biloxi, Miss.; Newton M. Davis to Providence Hospital, El Paso, Tex.; Elmo A. Derrick to University Hospital and Hillman Clinic, Birmingham, Ala.

John F. Edmondson to Milwaukee Sanitarium Foundation, Wauwatosa, Wis.; J. D. Elliott to Baroness Erlanger Hospital, Chattanooga, Tenn.; Dale Embich to Fitkin Memorial Hospital, Neptune, N.J.; Paul O. Erickson to Veterans Administration Research Hospital, Chicago; Lawrence W. Feil Jr. to Butterworth Hospital, Grand Rapids, Mich.; Peter Fronizer to Doctors' Hospital, Cleveland Heights, Ohio. Donald E. Glasford to Baptist Hospital, Alexandria, La.; Arthur G. Godin to Newton-Wellesley Hospital, Newton Lower Falls, Mass.; Edward A. Hall to Fairview Park Hospital, Cleveland; Robert L. Harris to Decatur and Macon County Hospital, Decatur, Ill.; John D. Hudson to Brackenridge Hospital, Austin, Tex.; Leland S. Johnsen to Emanuel Hospital, Portland, Ore.; John S. Johnstone to Department of Mental Health, Central State Hospital, Lakeland, Ky.; Yvonne G. Khouri to Pawating Hospital, Niles, Mich.; Albert A. Lassanske to Sherman Hospital, Elgin, Ill.

Norbert F. Lindskog to St. Luke's Hospital, St. Paul; Charles A. Markel to Perth Amboy General Hospital, Perth Amboy, N.J.; John L. Millard to Bethany Hospital, Kansas City, Kan.; William R. Mitchell to Louisville Medical Center, Louisville, Ky.; Carlos C. Monedero to Herrick Memorial Hospital, Berkeley, Calif.; Edwin W. Murphy to Little Company of Mary Hospital, Evergreen Park, Ill.

James A. Oakey to Loretto Hospital, Chicago, and Suburban Cook County Tuberculosis Sanitarium District, Hinsdale, Ill.; John P. Perry to University of Missouri Medical Center, Columbia; Dolores Quittmeyer Erickson to Chicago Wesley Memorial Hospital and North-

western University Medical School Clinics, Chicago; Ray G. Roberts to Western State Hospital, Bolivar, Tenn.; Myron Rose to Beth Israel Hospital, Boston; James L. Rule to Ponca City Hospital, Ponca City, Okla.

Erwin J. Saxl to Montefiore Hospital, New York; Herbert Schwartz to Jewish Hospital and Medical Center, Cincinnati; Jack O. Segall to Peter Bent Brigham Hospital, Boston; William L. Shepherd to Department of Mental Health, Central State Hospital, Lakeland, Ky.; Marion Shih to National Taiwan University Hospital, Taipai, Formosa.

James H. Smith to Bernalillo County-Indian Hospital, Albuquerque, N.M.; Bruce D. Sorenson to White Cross Hospital, Columbus, Ohio; Donald W. Spalding to Clara Maass Memorial Hospital, Belleville, N.J.; Donald M. Stewart to Methodist Hospital of Dallas, Dallas; David W. Stickney to Children's Memorial Hospital, Chicago; James E. Sullivan to Harrisburg Polyclinic Hospital, Harrisburg, Pa.; William R. Thompson to Methodist Hospital, Lubbock, Tex.; Rev. Roger A. Wagner to Evangelical Deaconess Hospital, Milwaukee; William A. White to Eastern State Hospital, Knoxville, Tenn.; Darwin E. Winfield to Medical Center Hospital, Tyler, Tex.

Washington University Announces Residencies

ST. LOUIS.—Administrative residencies have been announced for students in hospital administration at Washington University. Appointments are:

George Banjak to Methodist Hospital, Indianapolis; Robert Blincow to Veterans Administration Hospital, Houston; Richard Bogg to Good Samaritan Hospital, Vincennes, Ind.; Roy Creech to Memorial Mission Hospital, Asheville, N.C.; Donald Dinger to Wesley Hospital, Oklahoma City.

John Hankins to Scott Air Force Base, Belleville, Ill.; Kenneth Hawthorne to Pekin Public Hospital, Pekin, Ill.; Duane Houtz to Orange Memorial Hospital, Orlando, Fla.; Marshall Maggard to Hillcrest Memorial Hospital, Tulsa, Okla.

Cecil Melville to Baptist Memorial Hospital, Memphis, Tenn.; Dr. Pierre Mercier to Barnes Hospital, St. Louis; Donald Nelson to Methodist Hospital, Memphis, Tenn.; John Rice to Wesley Hospital, Wichita, Kan., and Vincent Schneider to Barnes Hospital, St. Louis.

Announce Building Plans

CHICAGO. — Two institutions have announced future building plans here. Mercy Hospital will build a new hospital in the immediate vicinity of its present location and Loyola University's Stritch School of Medicine is studying various proposals for a new medical school building to replace its present structure in the West Side Medical Center. Announcement was made jointly by Sister Mary Michael, administrator of Mercy Hospital, and the Very Reverend James F. Maguire, president of Loyola.

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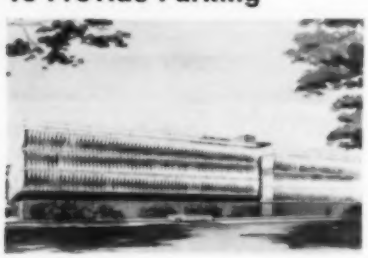

Ground was recently broken for this five-story, self-parking structure for the staff of the Henry Ford Hospital, Detroit. It will provide space for approximately 870 cars in a building congruous with the hospital.

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1. Adams, Ralph, M. D.: Med. Times, 86:1119-1127 (Sept.) 1958.

Initial clinical studies on Vi-DRAPE Film were conducted by Carl Walter, M.D., Peter Bent Brigham Hospital, Boston.

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Vacant Bed Costs $6742, Cleveland Study Shows

CLEVELAND. — Every unused hospital bed adds $6742 a year to the community's hospital bill, the Cleveland Citizens Hospital Study Committee reported in a study that warned against overexpansion.

A patient occupying the bed adds only $1829 to the average yearly cost per bed. "Most of the cost of maintaining a hospital bed ready for service continues whether or not the bed is occupied," the study group explained.

"It is obvious that Northeast Ohio must have an adequate number of hospital beds," the committee noted, "but it is equally clear that too many beds can be costly indeed."

An earlier report by the committee showed that Cleveland patients often go clear across the city for hospital services. This means, the report said, that excessive building in any section of the city poses something of a problem for every other section. Overbuilding adds to the net cost of the community hospital service.

Another recent study by the committee showed that people at the lowest income levels go to the hospital about as often as the highest income groups for medical and surgical care, but obstetrical services were used more by the low income groups. There were 35 obstetrical cases per thousand households in the lowest income group, compared to 13 cases per thousand for the 10 per cent with the highest income.

10 Health Agencies Raise $161.8 Million; Individual Giving Leads Philanthropy

NEW YORK.—Ten major national health agencies raised a total of more than $161.8 million during the last fiscal year, the American Association of Fund Raising Counsel has reported.

The association's report on philanthropic building for hospital, religious and education purposes showed construction for these areas totaled $484 million in the first quarter of 1959. Private hospital construction totaled $142 million, a decrease of 6 per cent from last year. Religious building rose 9 per cent and educational construction was up 5 per cent, the report said.

In its report on sources of philanthropic contributions for construction, the association said individual giving leads all other sources of philanthropic income, and in 1958 is estimated to have reached $5.6 billion, approximately five times more than all other sources combined.

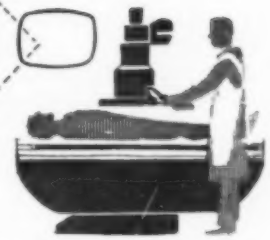
N. Y. Blue Cross Proposes Amendment on Home Care

NEW YORK. — An amendment to the state insurance law that would permit prepayment plans to cover nursing care and related services in the home following hospital care has been proposed by Associated Hospital Service of New York, the state's Blue Cross.

Passage of the amendment would permit Blue Cross to develop programs designed to reduce the cost of hospital care by shortening hospital stays and providing coverage for follow-up home nursing service in qualified cases, the proponents claimed in their announcement. Appliances, drugs, medicines and supplies that ordinarily would be provided in the hospital, as well as ambulance service, could also be made available, the announcement said.

DIRECT OPTICAL VIEWING ON AN 8" IMAGE INTENSIFIER

(2½ times field of usual 5" image)



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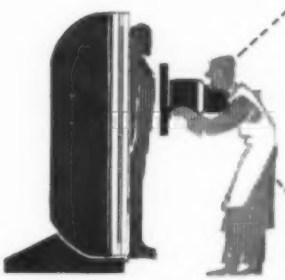
7 different spot patterns on an 8" x 10" film



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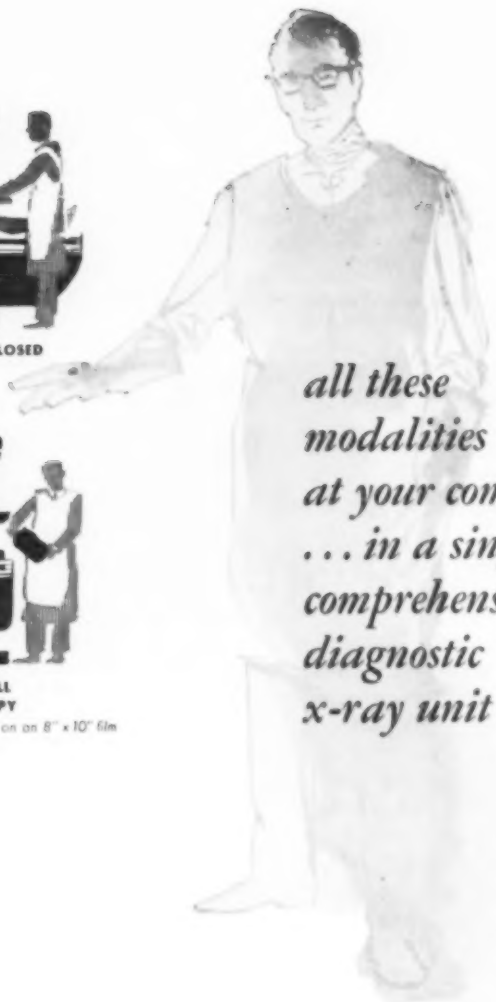
screen always at standby: slide it into or out of the field



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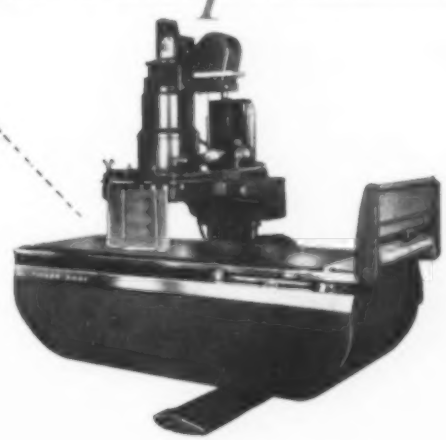


ABOUT PEOPLE

(*Continued From Page* 84)

John A. Erlman has been named assistant administrator of DeGoesbriand Memorial Hospital, Burlington, Vt. He was formerly at Mercy Hospital, Springfield, Mass. Mr. Erlman is a graduate of the program in hospital administration at Northwestern University.

Marie N. Oling has been appointed director of Shriners Hospitals for Crippled Children, Twin Cities Unit, Minneapolis. She was formerly administrator of McCray Memorial Hospital, Kendallville, Ind. Miss Oling is a graduate of the Northwestern University program in hospital administration.

Orville N. Booth, administrator of St. Francis Memorial Hospital, San Francisco, for the last 13 years, has been made vice president and administrator by the board of trustees.

Alan Blade has been named administrator of Pioneer Memorial Hospital, Viborg, S.D.

Lloyd L. Fray has been appointed administrator of Caney Valley Hospital, Wharton, Tex., following the resignation of **E. H. Moore.**

John O. Tucker, administrative assistant and night administrator at University Hospital and Hillman Clinic, Birmingham, Ala., has resigned to become director of personnel at Mobile Infirmary, Mobile, Ala. He has a master's degree in hospital administration from Northwestern University.

Keith M. Brown has been appointed administrator of John Burns Memorial Hospital, Belle Fourche, S.D., to replace **Harold Slater.** Mr. Slater has been named field representative for the division of hospital facilities of the South Dakota state department of health, Pierre.

Roy Steadler has assumed his duties as superintendent of Hubbard Memorial Hospital, Bad Axe, Mich. Mr. Steadler, formerly administrator of Bay County Hospital, Richmond, Mo., replaces **Clarence Murphy,** who resigned.

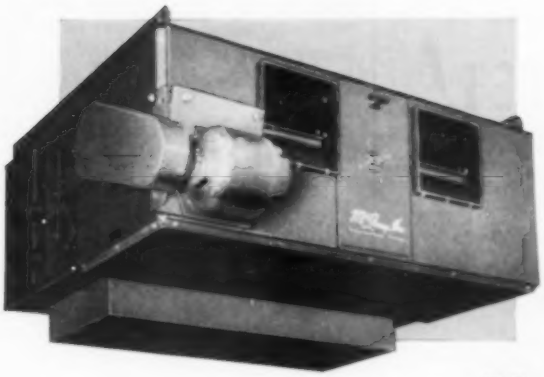
Dr. Robert Raymond Knowles has succeeded **Dr. Leslie Wright** as superintendent of Kentucky State Hospital, Danville. Dr. Knowles has served as clinical director of the hospital since August 1956. He is a graduate of the Medical School of Sydney University, Sydney, Australia. Before going to Kentucky his previous experience had been in mental hospitals in England.

Thomas J. Underriner has been appointed assistant administrator at Sacred Heart Hospital, Spokane, where he was previously administrative assistant. He is a graduate of St. Louis University's school of hospital administration and is a nominee of the American College of Hospital Administrators.

Roy Myers has been promoted from business office manager to assistant administrator at General Hospital, Greenville, Miss. He is currently vice president of the Mississippi chapter of the American Association of Hospital Accountants.

Frank Tripp has terminated 12 years' service as executive secretary-superintendent of hospitals operated by the Southern Baptist Convention. He is opening an office for the general practice of hospital consultation in Montgomery, Ala.

Edward P. Farage has been appointed administrator of Orthopaedic Hospital, Trenton, N.J. He is a graduate of Arizona State University and has had experience as business manager of Doctors' Hospital, Cleveland.



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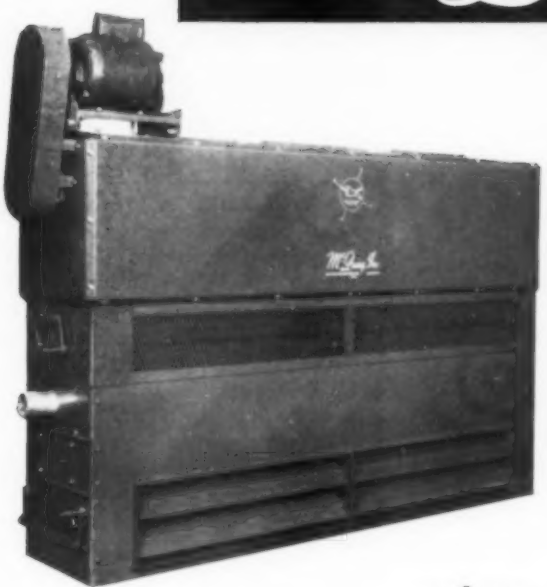

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and business manager and assistant administrator of Lancaster-Fairfield Hospital, Lancaster, Pa. He replaces **Robert M. Shelton,** who has been appointed executive director of the American Association of Hospital Accountants, Chicago.

C. Steacy Pickell has been named business manager of Psychiatric Receiving Center, Kansas City, Mo., moving there from a similar post with City of Kansas City hospitals.

Frank E. Conort, who has served as instructor in hospital accounting in the hospital administration course at Georgia State College for several years, has been appointed chief accountant at DePaul Hospital, Norfolk, Va.

Jack G. Fougerousse, administrator of Putnam County Hospital, Greencastle, Ind., has been named administrator of Dukes Memorial Hospital, Peru, Ind. He succeeds **David Shaw.** Mr. Fougerousse attended Indiana University, the University of Louisville, and Tulane University. He is past president of the Central Southwest Hospital Council and represents the council on the board of directors of the Indiana Hospital Association.

Sandy Anderson has been appointed assistant administrator of Grady Memorial Hospital, Atlanta. He recently completed the course in hospital administration at Georgia State College.

Jerry P. Smith, former administrator of North Houston Hospital, Houston, has been appointed administrator of Doctors Hospital, Dallas.

Leon Felson has been appointed administrator of General Hospital, Kansas City, Mo. The former assistant director of Menorah Medical Center, Kansas City, Mo., Mr. Felson has a master's degree in hospital administration from Northwestern University.

E. L. King has been appointed administrator of North Mississippi Community Hospital, Tupelo, succeeding **T. Ray Jones,** whose new appointment was announced in The MODERN HOSPITAL last month. Mr. King has been designated as the Mississippi Hospital Association representative to the first National Conference on Care of the Aged.

Franklin E. Simek has resigned as assistant administrator of Good Samaritan Hospital, Vincennes, Ind., to become administrator of Lafayette Home Hospital, Lafayette, Ind.

Dr. Ernest M. Tapp, manager of the Veterans Administration hospital,

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Odor	Heavy and penetrating.	None	Heavy	Heavy and lingering.	Some are heavy, others linger.	Very light and non-lingering.
Cleaning Ability	None, cause bleaching.	Poor, inactivated by soaps.	Good	Good	Good	Good
Microbiology	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	A nonselective germicide. Kills bacteria, virus, molds, fungi, yeast, spores, etc.
Affected by Hard Water	No	Yes	Yes	Yes	In some cases.	No
Indicator of Bacterial Efficiency	None	None	None	None	None	Color
Effect on skin, full strength	Irritants	Sensitizers	Irritants	Non-Irritating	Irritants	Non-Irritating
Toxicity	Yes	Variable	Yes	No	Yes	No

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Dearborn, Mich., has returned to the V.A. hospital at Poplar Bluff, Mo., as manager of the hospital and director of professional services. He was manager of the hospital there from October 1952 to June 1957.

Robert McGlynn has been named administrator of Memorial Hospital, Pullman, Wash., succeeding **Eugene Pray,** whose resignation was announced in The MODERN HOSPITAL in April. Mr. McGlynn, a graduate of the University of Minnesota course in hospital administration, taught hospital administration at St. Louis University and was administrative assistant at St. Agnes Hospital, Fresno, Calif.

Frank Mack Jr. has been appointed assistant director of Oakwood Hospital, Dearborn, Mich. He is a graduate of the school of public health, Columbia University, and has been assistant administrator of Community Hospital at Glen Cove, Long Island, N.Y.

William D. Gibson has assumed his duties as administrator of Decatur County Memorial Hospital, Greensburg, Ind. He is a graduate of the Medical College of Virginia with a master's degree in hospital administration.

Lee M. Thomas has succeeded **Harry W. Smith** as administrator of Walton County Hospital, Defuniak Springs, Fla.

Kenneth A. Dahl has been named successor to **Lloyd Inman** as administrator of Venice Memorial Hospital, Venice, Fla. He had previously been administrator of Randolph County Hospital, Pocahontas, Ark., and West Orange Memorial Hospital, Winter Garden, Fla.

Ethel Mangold, R.N., has been named superintendent at Bishop Randall Hospital, Lander, Wyo., succeeding **Leila Dodson.** Mrs. Mangold had been anesthetist at the hospital.

John McDonald has been named administrator of Washington County Hospital, Chipley, Fla. He succeeds **Isabella N. Williams,** who resigned in December. **Elmer D. Gilbert** had served as interim administrator.

Gene Slingerland has resigned as administrator of Childress General Hospital, Childress, Tex. Prior to his appointment as administrator two years ago he had served as x-ray and laboratory technician at the hospital.

Pearl Stickley has been named administrator of White Hall Hospital, White Hall, Ill., succeeding **Ina Bohannan** who resigned because of ill health.

Doris Warren has resigned as administrator of Memorial Hospital, Neillsville, Wis. She had been administrator since the spring of 1955, and had been associated with the hospital since 1953. Her successor will be **John Temte,** former administrator of Municipal Hospital, Reedsberg, Wis.

Dr. Samuel L. Aspis, manager of the Veterans Administration hospital at Poplar Bluff, Mo., has been named manager of the V.A. hospital at Kansas City, Mo.

Flora V. Parkerson, R.N., has been named administrator of Gothenburg Memorial Hospital, Gothenburg, Neb.

Lawrence Krizan has been appointed controller of Midland Memorial Hospital, Midland, Tex.

Jack C. Kirkland has been named chief pharmacist at Talmadge Memorial Hospital, Augusta, Ga. He completed the course in hospital administration at Georgia State College.

Department Heads

Dr. Rocco Latorraca has been appointed pathologist at Trinity Memo-

rial Hospital, Cudahy, Wis., succeeding **Dr. J. J. Kurtin,** who died.

Mildred E. Schwier, director of the National League for Nursing's department of diploma and associate degree programs, has been appointed director of nursing at Rhode Island Hospital, Providence, R.I. She has been succeeded at the N.L.N. by **Frances K. Peterson,** who has been assistant director of the department. Miss Schwier has bachelor's and master's degrees from Teachers College, Columbia University. Before joining the N.L.N. she was director of nurses at Mt. Vernon Hospital, Mt. Vernon, N.Y., and General Hospital, Pittsfield, Mass. Miss Peterson has a bachelor's degree from St. John's University, Brooklyn, N.Y., and a master's degree in nursing education from Catholic University, Washington, D.C.

Mildred Schwier

Frances Peterson

James A. Faries has been named personnel director of Research Hospital, Kansas City, Mo. Mr. Faries, a graduate in business administration from Indiana University, has been completing work on a master's of hospital administration degree at Washington University. He had served four years as a medical administration clerk with the U.S. Air Force.

Wilhelmina M. Nolan has been appointed director of nursing at Galesburg State Research Hospital, Galesburg, Ill. She is a graduate in nursing education and administration of Teachers College, Columbia University. Her appointment followed the resignation of **Cornelia Knight,** who became executive secretary of the American Nurses' Association.

Lucy Germaine, director of nursing at Harper Hospital, Detroit, has been appointed executive director of the American Journal of Nursing Company, succeeding **Pearl McIver.**

Johanna F. Sutton has been appointed director of nursing at Queen of Angels Hospital, Los Angeles. Mrs. Sutton has been night supervisor of obstetrics at Los Angeles County General Hospital, Los Angeles, and prior to that was supervisor of obstetrics

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*Carl W. Walter, M.D., "Aseptic Treatment of Wounds" (New York: The Macmillan Company, 1954), P. 172

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and gynecology at U.C.L.A. Medical Center, Los Angeles. She served as supervisor of medical and surgical divisions for the U.S. Army Nurse Corps, and later was a member of the faculty at Gonzaga University, Spokane, Wash.

Miscellaneous

Anna Fillmore, first general director of the National League for Nursing since the reorganization in 1952, has resigned to become director of the New York Visiting Nursing Service.

Dr. Cyrus H. Maxwell, a member of the American Medical Association's Washington office staff since March 1950, has resigned to take a position in commissioned corps of United States Public Health Service. He will represent the service in planning and arrangements for the White House Conference on Aging in Washington in 1961.

Maj. Gen. Elbert DeCoursey has been named director of Southwest Foundation for Research and Education, San Antonio, Tex. He will also be appointed full professor at Trinity University with the title of director of scientific research. Dr. DeCoursey has been commandant of the Army Medical Service School and clinical professor of pathology at Baylor College of Medicine. He is a graduate of Johns Hopkins Medical School. Before going to Baylor he had directed the work of the Armed Forces Institute of Pathology in Washington, D.C. He was a member of the Joint Commission for the Investigation of Effects of the Atomic Bomb in Japan in 1945 and a member of the Naval Medical Research Section at Bikini. In 1956 he was sent to Japan as a consultant to the National Research Council on its research program on survivors of the atomic bombing. He is a member of the Council for Research and Education of the American Hospital Association.

Col. Larry A. Smith has been named director of medical staffing and education, office of the surgeon general, U.S. Air Force, beginning June 30. He replaces **Brig. Gen. M. S. White,** who has been assigned as surgeon of the air training command.

Dr. Thomas M. Arnett, Veterans Administration area medical director in Trenton, N.J., has been appointed deputy director for planning for the V.A. department of medicine and surgery, Washington, D.C.

Joseph J. Wesner has been appointed director of financial studies for the St. Louis Hospital Council, St. Louis. He formerly had been with Massachusetts Hospital Service, Inc., as a consultant to the state commission on hospital costs and finances.

Rena Boyle, nurse consultant with the division of nursing resources, Public Health Service, has been designated to head the division's newly created nursing research and consultation branch. This branch combines the functions formerly carried out by the nursing services branch and the nursing education branch.

Robert Parnall, general manager of Connecticut Blue Cross, Inc., since 1957, has retired. **Joseph F. Duplinsky** succeeds Mr. Parnall. Mr. Duplinsky, who joined the organization in 1938, has been assistant general manager for the last nine years.

Deaths

Donald R. Bergstedt, 33, assistant director of Oakwood Hospital, Dearborn, Mich., since 1952, died recently. He was a nominee of the American College of Hospital Administrators.

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PATHOLOGIST—3 years, army medical officer; 4 years, associate pathologist, large hospital; now completing, hematology residency; will take boards in fall; seeks hospital, clinical pathology; east or midwest.

RADIOLOGIST—10 years, academic medicine radiology; past 4 years, professor & head of radiology department; important medical school—also consultant; well-qualified, isotopes; numerous publications; now seeks hospital practice; outstanding specialist.

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ANESTHESIOLOGIST—Well qualified and experienced; available immediately.

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EXECUTIVE HOUSEKEEPER—Excellent background hospital and hotel experience; desires locate California or Ohio.

X-RAY TECHNICIAN—Male; at present heads technical laboratory performing EEG, Vascular temperature test, cardiographs, BMR, audiometric studies, cardiac catherization, phono-cardiogram and bronchial spirometric recorder; desires position offering advancement in field.

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(Continued on page 181)

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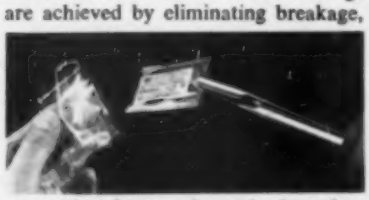

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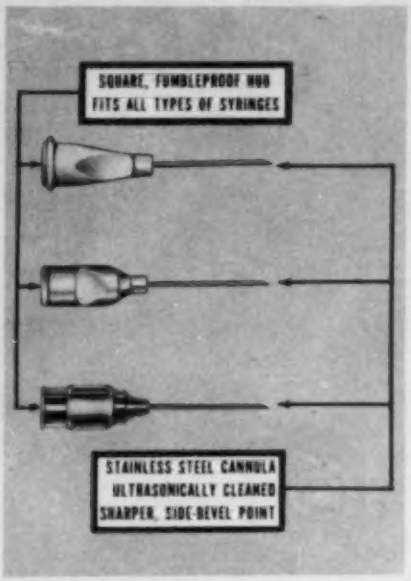

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POSITIONS OPEN

ANESTHETIST—Nurse; 10 complete staff of eight; 604-bed general hospital in northeast Ohio; salary open, generous employee benefits; no pediatric department; 40 hour week, plus overtime. Apply MO 272, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Nurse; in small rural hospital southwest area, approved J.C.A.H.; one surgeon (F.A.C.S.); few OB's this is an ideal situation for an older anesthetist who does not desire to work too hard; but also ideal for one who enjoys small towns, and small hospitals; the salary is open and will be adequate, plus a bonus plan; state qualifications, salary desired and date of availability in first letter; hospital will pay travel expense for interview to proper applicants. Write MO 276, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

ANESTHETIST—Lutheran Deaconess Hospital, a 200-bed general hospital located on the near Northwest side of Chicago is in need of an anesthetist for a permanent full time position beginning July 1, 1959; for details write to the Executive Director, Lutheran Deaconess Hospital, 1138 N. Leavitt Street, Chicago 22, Illinois.

ANESTHETISTS—Nurse; for 220-bed community hospital; working with private group; two full time M.D.'s, four nurses, all agents and techniques; modernization program going on; two and one-half hours from Boston and New York. Write G. J. Carroll, M.D., William W. Backus Hospital, Norwich, Conn.

ANESTHETIST—Nurse; need immediately; 185-bed, general hospital, college town, 20,000 population, recreational area, $600 a month. Contact H. B. Lehwald, Administrator, St. Luke's Hospital, Marquette, Michigan.

ANESTHETIST—Must be graduate of accredited school and adept at all types of inhalation and intravenous anesthesia; anesthesiologist heads department; 150-bed hospital; good personnel policies. Apply St. Mary's Infirmary, 1536 Papin Street, St. Louis 3, Missouri.

ANESTHETIST—Nurse-Director of Nurses; 26-bed general hospital; college town; no O.B. salary $500 to $600 per month. Apply Administrator, Crete Municipal Hospital, Crete, Nebraska.

ANESTHETIST—Nurse; trained and experienced; graduate of approved nursing school with specialized training course in anesthesia; salary range $4750-$6178; paid vacation and sick leave; maintenance available for a single person. Apply Charles R. Walton, Personnel Director, New Jersey State Hospital, Trenton, New Jersey.

ANESTHETIST—Nurse; immediate openings in fully accredited 300-bed general hospital for nurse anesthetist in city of 55,000 and serving area of 300,000 population; paid vacation and sick leave, social security and group hospitalization available. Reply stating education, experience, and salary requirements to Assistant Director, Lima Memorial Hospital, Lima, Ohio.

ANESTHETIST—Nurse; female; accredited modern 250-bed hospital, all new surgery wing; department directed by anesthesiologist; starting wage $500 plus liberal annual increase, three weeks vacation, health insurance, sick leave, retirement plan; American Board surgeons. Apply to Elmer J. Berg, Business Manager, Gundersen Clinic, 1836 South Avenue, La Crosse, Wisconsin.

DIETITIAN—Chief; A.D.A. registered, in a 218-bed fully approved general hospital with approved school of nursing; experience necessary; liberal personnel policy; democratic atmosphere; salary open; located on Hudson River, one hour from New York City. Write MO 283, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinoss.

DIETITIANS—A.D.A.; very desirable positions available for therapeutic supervisors in hospital division of our progressive Industrial Food Service Company; forty hour week, two week vacation, two weeks sick leave, meals furnished, group hospitalization insurance available; top salaries; responsible for complete administration of patient food service; school of nursing. Apply Miss Rita Bedessem, Director; Hospital Division, Cooper Industrial Food Services, Inc., 5875 North Lincoln Avenue, Chicago 45, Illinois.

DIETITIAN—Relief; 340-bed hospital and clinic; 40 hour week, fringe benefits, paid vacation. Apply MO 280, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

DIETITIANS—To work for food service company with operations in principal West Coast cities and Denver; formal 10 week training program followed by assignment involving full range of management activities; excellent opportunity for development and advancement; salary open. Reply to Food Service Management Division, Manning's, Inc., 901 Battery Street, San Francisco 11, California.

DIETITIAN—Position being created by opening of 120-bed rehabilitation addition to Iowa Methodist Hospital; excellent opportunity for ADA registered hospital trained person; possibility of work in either therapeutic or administrative areas; good pay, liberal benefits. Apply Personnel Director, Iowa Methodist Hospital, Des Moines 14, Iowa.

DIETITIAN—Therapeutic; to assume charge of special diet office; 400-bed hospital; new dietary department; salary open, many fringe benefits. Apply to Isabelle Moerke, Personnel Director, St. Mary's Hospital, 407 East 3rd Street, Duluth, Minnesota.

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Therapeutic; to relieve administrative dietitian; beginning salary $350.00 per month, 40 hour week, with vacation, promotions and other benefits; new 166-bed hospital, excellent medical staff; immediate opening; if interested, contact W. B. Talbot M.D., Administrator, Butte Community Memorial Hospital, Butte, Montana.

DIETITIAN—Chief of department; A.D.A. member or eligible for registration; 90-bed hospital; liberal vacation, holidays and sick allowance; salary open. Contact Emil Wieland, Administrator, Jamestown Hospital, Jamestown, North Dakota.

DIETITIAN—Therapeutic; $5,000 beginning salary; exceptional opportunity for advancement—merit system; 503-adult bed, 72 bassinet general hospital. Apply Director of Dietetics Aultman Hospital, Canton 10, Ohio.

DIETITIAN—Chief; Municipal TB Hospital, J.C.A.H. approved, excellent salary, permanent position; must be ADA member. Apply Superintendent, Wm. Roche Memorial Hospital, Toledo 14, Ohio.

DIETITIAN—Therapeutic; A.D.A.; immediate opening; 100-bed general hospital; 5 day week, paid vacation, sick leave, special holidays; salary commensurate with qualifications. Contact Dietitian, Grace Hospital, Richmond 20, Virginia.

DIETITIANS—Staff; 2; Capitol City's largest and newest hospital; 290-adult beds; opened 1951; centralized food service, selective menu, ADA preferred; no teaching required; $4,000 starting salary range; liberal personnel policies. Apply Director of Dietetics, Charleston Memorial Hospital, 3200 Noyes Avenue, Charleston 4, West Virginia.

DIRECTOR OF NURSES AND SCHOOL OF NURSING—Master's Degree in Nursing Education desirable; salary open; modern 460-bed general community hospital located on Eastern Seaboard. Apply MO 277, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING—With B.S. preferred in 112-bed, modern, well staffed and newly equipped hospital; $475.00 minimum. Contact Administrator, Richland Memorial Hospital, Olney, Illinois.

DIRECTOR OF NURSING—For JCAH approved general hospital; after large addition is completed late this year, will have 240-beds (including a 30 bed Psychiatric Unit) and 44 bassinets; State approved Diploma School of Nursing; first inspection by NLN scheduled for early 1960; prefer applicant with M.S. degree and several years of administrative experience; starting salary around $7500 plus maintenance. Apply Administrator, W. A. Foote Memorial Hospital, Jackson, Michigan.

SUPERVISOR OF NURSES—For Bound Brook Hospital; state references and salary. Write Dr. Benjamin Borow, Medical Director, Bound Brook Hospital, 507 Church Street, Bound Brook, New Jersey.

DIRECTOR OF NURSING—Unusual opportunity for nurse who is presently serving as supervisor, assistant director or director to conduct reorganization program and plan for new hospital; salary negotiable with attractive increases according to performance; exceptional opportunity for advancement in the field; would consider person wishing to make this position a stepping stone to similar position in larger hospital; university facilities available for advance courses; interview expenses paid. Write Bethesda Hospital, Hornell, New York.

ADMINISTRATIVE SUPERVISOR OF NURSING SERVICE—270-bed hospital; minimum requirements: B.S. degree in Nursing; experience as supervisor preferred; salary commensurate with degree and experience; school of nursing affiliated with community college. Write Mrs. Isabel Christiana, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York. Phone GLobe 2-3000, Ext. 241.

DIRECTOR OF NURSING—Progressive 70-bed children's rehabilitation-convalescent center in New York metropolitan area; good staff, liberal personnel policies, modern apartment; salary open; Masters degree required. Write W. H. Kelley, Executive Director, Blythedale, Valhalla, New York.

DIRECTRESS OF NURSES—For 170-bed hospital; Central Pennsylvania; salary commensurate with qualifications plus an apartment. Contact Mr. Richard E. Cummings, Administrator, J. C. Blair Memorial Hospital, Huntingdon, Pennsylvania.

HOUSEKEEPER—Executive; An outstanding hospital in the midwest; unusually progressive; this is a challenging position; salary is definitely open; please state experience, training, and present salary. Apply MO 282, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

(Continued on page 184)

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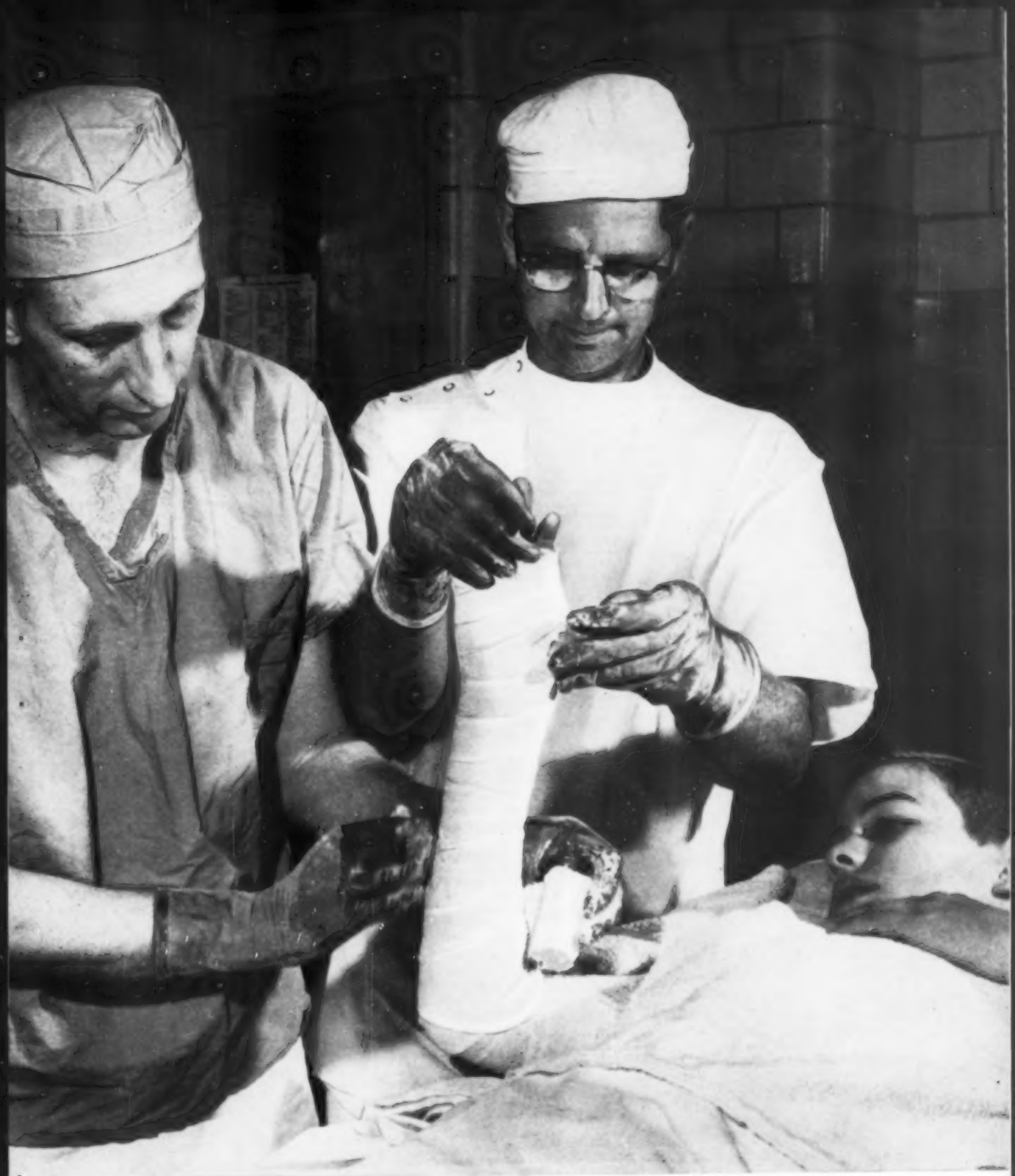

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HOUSEKEEPER—Assistant; 185-bed modern hospital; to serve as full assistant in an expanding department, capable of training and instruction, 2 years hospital experience desired; liberal employee benefits; salary open. Apply to Executive Housekeeper, Mount Sinai Hospital, Hartford 12, Connecticut.

INSTRUCTORS — Medical-surgical; fundamentals of nursing; and medical-surgical specialties; 225-bed hospital; N.L.N. provisionally accredited school of nursing, 100 students; B.S. and teaching experience desirable; liberal personnel policies; minimum salary for qualified person $400 per month. Apply to Director of Nursing Education, Allen Memorial Hospital, Waterloo, Iowa.

INSTRUCTORS—Clinical; needed in following categories; to coordinate student learning experience in medical and surgical nursing; to teach operating room technique; 90 student, 3 year diploma program affiliated with community college; minimum requirements; B.S. degree in Nursing Education, Masters preferred; experience as clinical instructor required; salary commensurate with degree and experience. Write Mrs. Isabel Christiana, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York. Phone GLobe 2-3000. Ext. 241.

INSTRUCTORS—Two for medical-surgical nursing, and one for fundamentals of nursing; school with excellent teaching facilities, 190 students; a 400-bed hospital; liberal personnel policies, with group life insurance benefits; degree required, salary commensurate with training and experience. Apply Director of Nursing, Saint Mary's Hospital, Huntington, West Virginia.

LAUNDRY MANAGER—340 bed hospital; salary open, experience necessary. Contact Raymond Clark, Assistant Administrator, Robert Packer Hospital, Sayre, Pennsylvania.

LIBRARIAN—Medical records; experienced and trained to work in mental hospital; paid vacation, sick leave and free life insurance may provide room and board at nominal rate. Apply MO 281, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Chief medical records; to take charge of a fully staffed department in a modern and progressive hospital organization; excellent starting salary, review yearly, and no ceiling; extensive benefits, including three weeks vacation after one year and four weeks after five years; we are willing to pay interviewing expenses, and if hired we will share moving expenses. Apply MO 284, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Assistant medical record; 300-bed hospital; salary commensurate with those in area. Apply Administrator, St. Joseph's Infirmary, 265 Ivy Street, N.E., Atlanta 3, Georgia.

LIBRARIAN—Medical records; for 58-bed general hospital; to be in charge of the medical records library; desirable personnel policies and starting salary; located in a resort city on the shores of Lake Michigan. Write or call collect; Ralph W. Tarr, Administrator, Grand Haven Municipal Hospital, Grand Haven, Michigan.

LIBRARIAN—Chief medical records; for 290-bed, fully accredited hospital; well organized department; college town of 80,000; salary range from $400 to $500. Apply Personnel Director, Springfield City Hospital, Springfield, Ohio.

LIBRARIAN—Registered medical record; to take charge of a medical record library in a new modern 160-bed general hospital, JCAH accredited; pleasant working conditions; salary open. Apply Personnel Director, Miriam Hospital, 164 Summit Avenue, Providence, Rhode Island.

MISCELLANEOUS — Openings in large modern general hospital, Southern Metropolitan City, for; registered physical therapist, nurse anesthetists, A.D.A. dietitians, pharmacist, medical technologists and nursing education instructors; progressive personnel policies, excellent working conditions; salary based on preparation and experience. Address MO 265, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS—Positions available Head Nurses and Staff Nurses Day, Evenings and Nights; differential salary for evenings and nights; salary commensurate with experience and educational background; generous personnel policies; school of nursing affiliated with local community college; modern round wing opens in fall; located near New York. Apply MO 278, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

MISCELLANEOUS — Supervisor-Operating Room; also openings for General Duty Registered Nurses; 85-bed hospital, fully approved by Joint Commission Western Pennsylvania; situated in famous resort area, attractive salary, liberal personnel polices. Apply to Mrs. E. Thompson, R.N., B.S., Director of Nursing, Memorial Hospital of Bedford County, Bedford, Pennsylvania.

(Continued on page 187)

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- **Chassis**—Is it a lightweight, flat steel frame or heavy duty angle steel?
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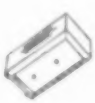

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MISCELLANEOUS NURSING—Operating Room Nurses and Staff Nurses; the new Palo Alto-Stanford University Medical Center; $340 to $380 per month, experience and preparation recognized; $20 shift premium for 3-11 and 11-7; shift rotation in operating room service rotation in medical and surgical divisions. Licensed Vocational Nurses; $290 to $320 per month; $10 shift premium; orientation program for all new employees and 2 to 4 weeks vacation, social security, hospitalization insurance, sick benefits, retirement program, 40 hour week. Apply Director of Personnel, Palo Alto-Stanford University Medical Center, Palo Alto, California.

NURSES—General duty; immediate positions available in 600-bed general hospital in northeast Ohio; 11:15 P.M. to 7:15 A.M. or 3:00 P.M. to 11:30 P.M. shift; no pediatric department; consideration given to the preference of service desired; 40 hour week; generous employee benefits. Apply MO 279, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered; responsible positions open; beginning salary $270 month; recently constructed 35-bed general hospital located only 3 hours from gulf coast. Apply Administrator, Jackson Hospital, Jackson, Alabama.

NURSES—Surgery; must be experienced; beautiful 83-bed hospital in Los Angeles suburb; excellent salary and working conditions; 5 day week. Apply Administrator, San Gabriel Valley Hospital, 115 E. Broadway, San Gabriel, California.

NURSES—Registered; positions open on all shifts and services including delivery and operating room; modern 60-bed hospital located in southwest Colorado; nurses must be eligible for Colorado registration; 40 hour week, paid vacations; social security, holidays, liberal sick leave and other benefits; modern quarters available for single personnel if desired. Apply Southwest Memorial Hospital, Cortez, Colorado.

NURSES—Staff; positions in all clinical areas including psychiatry and respiratory center in new 800-bed air-conditioned hospital; 40 hour week; 3 weeks vacation annually; sick leave; beginning salary $300 monthly; periodic increments; opportunity for college study through bachelor's degree program. Write Director of Nursing Service, Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

NURSES—Registered; operating room and general duty for 350-bed hospital in western suburb, 16 miles west of Chicago's loop; starting salary for experienced operating room nurses $350; starting salary for general duty $325; differential of $15 for P.M. and night shifts; compensation of $2 a day for weekend duty, 6 paid holidays and other liberal benefits. Apply Mrs. Strong, Personnel Director, Memorial Hospital, Elmhurst, Illinois.

(Continued on page 188)

classified advertising

POSITIONS OPEN

NURSES—Registered; openings in pediatrics, obstetrics, medical-surgical and recovery room; modern 104-bed hospital in beautiful lake shore suburb of Chicago; living quarters on hospital grounds. Apply Director of Personnel, Lake Forest Hospital, Lake Forest, Illinois.

NURSE—General staff; interesting career positions with Oakland County in the Pontiac area; salary $4400 to $4700 depending upon qualifications and experience; excellent fringe benefits offered; must have registration with State of Michigan. Apply at Personnel Office, Oakland County Office Building, 1 Lafayette Street, Pontiac, Michigan. FEderal 3-7151.

NURSES—Registered; modern 98-bed hospital in Central Michigan; excellent salary and fringe benefit program; nurses residence available. Apply Clinton Memorial Hospital, St. Johns, Michigan.

NURSES—Registered professional; for supervisory, educational and general staff positions; liberal personnel policies; 40 hour week, differential salary for evening, nights and operating room; social security. Apply Christ Hospital, 176 Palisade Avenue, Jersey City, New Jersey.

NURSES—Registered; for general duty; 76-bed hospital; salary $260 & $15 3-11, $20 11-7 per month. $5 per month increase after 6 months service; 40 hour week, 2 weeks vacation and holidays with pay after 1 year; nice college town. Apply Director of Nursing Service, Jamestown Hospital, Jamestown, North Dakota.

NURSES—Operating room and general duty; new 50-bed general hospital; northwest Ohio at turnpike, 40 hour week, paid vacations and sick leave, pension plan, liberal differential payment for evenings and nights. Apply Administrator, Williams County General Hospital, Montpelier, Ohio.

NURSES—Registered general duty; 100-beds; good bedside nursing required, 40 hour week; rotating duties; excellent personnel policies; you arrange for Rhode Island State Registration. Apply Nurse Director, Jane Brown Memorial Hospital, Providence 2, Rhode Island.

NURSES—Registered; for 50-bed general hospital; approximately 7,000 population; 48 hour week, 2 weeks paid vacation after one year; sick leave, holidays, liberal personnel policies; nurses residence available; starting salary $325 a month and full maintenance. Write Administrator, Coon Memorial Hospital, Dalhart, Texas.

NURSES—Registered; move to the great southwest; for general duty and operating room; good salary and fringe benefits, 40 hour week; (nursing service) Apply Personnel Office, Harris Hospital, Fort Worth, Texas.

NURSING—General duty; for modern 72-bed air-conditioned JCAH accredited hospital located on Texas Gulf Coast; also industrial nursing; many benefits including paid vacation, sick leave, group insurance, retirement, stock purchase plan, etc.; excellent working conditions, salary commensurate with experience and ability. Send complete resume of education, training, experience and references in first letter, to the Dow Chemical Company, Personnel Department, Freeport, Texas.

NURSES — Registered; supervisors and general duty on all shifts and services; starting salary $250 for 40 hours or $290 for 48 hours weekly, guaranteed salary increases each 6 months for 2 years, differential for evenings $15, nights $10; modern, well equipped 35-bed JCAH accredited hospital; 6 paid holidays, 2 weeks vacation, 7 days sick leave or 3 weeks vacation without sick leave, social security, Blue Cross, meals on duty, laundry of uniforms; immediate employment if desired. Apply Administrator, Webster Memorial Hospital, Webster Springs, West Virginia.

PHARMACIST—Registered; male or female; for 400-bed general hospital in Hawaii; liberal personnel policies, hospitalization coverage, group life insurance, retirement, 40 hour week; state salary desired. Write Personnel Director, The Queen's Hospital, P. O. Box 861, Honolulu, Hawaii.

PHYSICAL THERAPIST—170-bed general hospital; salary open; excellent opportunity. Apply Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

SUPERVISOR-INSTRUCTOR — Operating room; 209-bed general hospital; NLN fully accredited school of nursing; 90 students; 40 hour week; special clinical preparation in operating room supervision; salary open, liberal personnel policies. Apply Director of Nursing, Middlesex Memorial Hospital, Middletown, Connecticut.

(Continued on page 189)

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POSITIONS OPEN

SUPERVISOR—Operating room; for new well equipped 3 room surgical department in 75-bed general hospital; R.N. with post-graduate surgical training preferred, will consider R.N. with surgical experience; excellent salary and working conditions; housing available on hospital premises; position available on or before September 1st. Write Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

TECHNICIAN—Laboratory; Western New York area; A.S.C.P. membership desirable but not essential; in applying give qualifications and references; liberal vacation, sick leave, and fringe benefits; salary open. Apply to MO 274, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNOLOGIST — Registered medical; A.S.C.P.; male or female; required immediately for an 85-bed, rural J.C.A.H. approved general hospital, situated midway between Pittsburgh and Harrisburg; famous resort area; salary open. Apply Memorial Hospital of Bedford County, Bedford, Pennsylvania, or Telephone the Director BEdford 655.

TECHNICIAN—Combination laboratory and X-ray; modern 28-bed general hospital in attractive growing community in the foothills of the Cascade mountains; salary to start $425.00 with meal at noon, and laundry of uniforms, plus Blue Cross medical dues. Contact Superintendent, Community Memorial Hospital, Enumclaw, Washington.

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ADMINISTRATORS—(a) Director of medical education; one of specialty Boards preferred; relatively new hospital, 450-beds; resort city, south; $12-$15,000. (b) Medical director to succeed superintendent retiring, after long tenure; $25,000; east. (c) Medical director, new 250-bed hospital; medical center, mid-west. (d) Superintendent; new hospital opened for operation by large industrial company, Africa. (e) Assistant director qualified to direct out-patient and emergency activities; 450-bed teaching hospital, New England. (f) Assistants to directors of Professional Administrative Services and Patient and Personnel Services; preferably recent course graduates; 1000-bed teaching hospital; south. MH7-1.

ADMINISTRATIVE PERSONNEL — (a) Personnel director; 350-bed general hospital; college town near Chicago; $6-10,000. (b) Comptroller, outstanding qualifications; take over financial control foreign university; experience as assistant controller large university, ideal; (c) Office manager and comptroller; 350-bed hospital; woman eligible; university city, midwest; $8-10,000. (d) Assistant purchasing agent; degree in business administration or allied field plus 3 years experience desired; large teaching hospital; east. MH7-2

MEDICAL BUREAU—Continued

ANESTHETISTS—(a) For staff of two; 125-bed hospital; Iowa town of 15,000; $8500; (b) Complete responsibility for department, 50-bed hospital, Illinois; $8500; (c) Anesthetist-director of nurses, 75-bed industrial hospital; light anesthesia; top salary, complete maintenance, south; (d) Join staff, general hospital, Hawaii; $5700; MH 7-3

DIETITIANS—(a) Chief, well known research center, vicinity, New York City; excellent salary; (b) Staff and supervisory; leading restaurants; $5-10,000. MH 7-4

DIRECTOR OF NURSES—(a) Director nurses, service and school; 250-bed general hospital; 100 students; Pennsylvania; $9000; (b) Director Nursing school and service, 600-bed hospital Eastern seaport; $10,000.. (c) Chairman, department of nursing education; West Coast Junior College; $7500 up; 10 month appointment; (d) Alaska; all graduate staff; $7000 up, complete maintenance. MH 7-5

EXECUTIVE HOUSEKEEPER — 300-bed hospital, south; $5-6000; MH 7-9

FACULTY APPOINTMENTS—(a) Direct fully integrated four-year collegiate school of nursing; top salary; midwest. (b) Medical-Surgical, Ob instructors, Hawaii; $5-6000; (c) Director, Nursing Education; 140 students; prominent hospital; southwest; $9000. MH 7-6

FOREIGN—(a) Head nurses, pediatric, surgery; $770. (b) 6 staff; $625; new 300-beds; all expenses. MH 7-10.

MEDICAL RECORD LIBRARIANS—(a) Head records department, 200-bed hospital near Cape Cod; top salary; (b) Set up department, brand new 60-bed hospital near Ozarks; top salary; MH 7-7

(Continued on page 190)

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POSITIONS OPEN

MEDICAL BUREAU—Continued

SUPERVISORY NURSES—(a) Operating Room Supervisor; top position in department of 43; 400-bed teaching hospital; excellent salary; Texas; (b) Floor supervisor ready to assume direction nursing service; 80-100 bed hospitals; opportunities, Arizona, Ohio, Illinois, New York; $5000. MH 7-8

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ADMINISTRATORS—(a) Medical directorr; very large, fully-approved, general hospital; about $20,000; west coast. (b) 700-bed, general hospital, fully-approved; substantial; city 120,000, east north-central. (c) 100-bed, voluntary, general hospital; Pennsylvania. (d) 60-bed, general hospital, now building 60-bed addition; new post; salary open; central. (e) 50 bed, private hospital; $10-15,000; excellent location, California. (f) 100-bed JCAH, general hospital, completing 75-bed addition; $10-12,500; south. (g) 350-bed general hospital; requires degree and minimum five years experience; New York State. (h) Assistant administrator; MS; must be personable, able accept responsibility; 250-bed, JCAH, general hospital; delightful, cultural, university town 30,000, midwest. (i) Assistant administrator; full charge, staff, purchasing; 350-bed, JCAH hospital; to $7800; south. (j) Assistant; 300-bed hospital; 2-3 years experience; if more, $12,000; California.

WOODWARD—Continued

ADMINISTRATIVE Posts—(k) Administrative assistant; medical-school-affiliated, 200-bed hospital; excellent potential; $7-8,000; California. (l) Comptroller; 100-bed, JCAH hospital; established 1894; $7-8,000; large, university city, east. (m) Purchasing agent; 110 bed, JCAH hospital; $6,000; east.

A & G MEDICAL PERSONNEL AGENCY

834 Second Street

Lancaster, Pennsylvania

ADMINISTRATION—Administrative assistant, capable handling public relations and personnel affairs; M.A. in Hospital Administration preferred, salary high. Pennsylvania.

BIOCHEMIST—M.A. in Biochemistry; 215-beds, 93 physicians on staff; salary dependent on individual qualifications and experience; personal interview arranged; nice location.

BACTERIOLOGIST—B.S. level; charge bacteriology section laboratory; large hospital, salary open, midwest location.

PHARMACIST—(a) Hospital and large group practice with expansion program; future good; salary to $6,500, Florida. (b) Assistant, 300-beds, air conditioned, salary open; Maryland.

A & G MEDICAL—Continued

ANESTHESIOLOGIST—Board Certified, become chief of service, 183-beds, salary or other basis, Virginia.

SURGEONS — PSYCHIATRIST-PATHOLOGISTS-HOUSE PHYSICIANS-WARD PHYSICIAN—(a) Board Certified Surgeon; practice connected with hospital; south. (b) Orthopedic surgeon; 202-beds, general medical surgical hospital; midwest. (c) Psychiatrist; 1700-beds, mental, very high salary, hospital will pay travel expenses for interview; midwest. (d) Pathologist; 135-beds, expansion to 2-beds; immediate opening, Pennsylvania. (e) Pathologist; Chicago area, 100-beds and expanding, salary open. (f) House physician; 130-beds, salary to $10,000 and quarters for unmarried, Pennsylvania license or eligible by reciprocity. (g) House physician; 85-beds, salary open, New York. (h) House physicians; 2; 100-beds, excellent living conditions, midwest. (i) House physicians; 2; 58-beds with affiliation large teaching institution; living accommodations for one, Pennsylvania. (j) Medical ward physician; general medical surgical hospital, midwest.

ENROLLMENT DIRECTOR — Assistant manager for Blue Cross and Blue Shield plan; preferably have some experience along or associated to this field.

FOOD MANAGER—Male; 360-beds, buying experience preferred, salary high, south.

DIETITIANS—(a) 72-beds, Municipally owned, salary $4,000; New York. (b) ADA preferred; 115-beds, plan and direct department, salary open discussion, midwest. (c) 90-beds, excellent working conditions, salary open, Michigan. (d) Administrative and therapeutic; 400-beds, teaching institution, college and resort city, salary depending on experience, 40 hour week, midwest location.

(Continued on page 192)

American-Standard Remotaire air conditioning units solve hospital expansion problem

WHISPER-QUIET UNIT cools one room while an adjoining unit may be heating the next. Unusual flexibility is ideal for between season use and to meet varying comfort and health requirements of patients.

The tough problem of cooling and heating the fourth floor addition to the Forrest County General Hospital was solved without expensive addition to the piping system. American-Standard Type 40 Remotaire units were installed. These year 'round air conditioning units at Forrest County General Hospital are completely self-contained—no central plant, cooling tower, pump, pipes or ducts were needed. Electricity powers the refrigerant circuit and heating coils.

Because this system is so flexible, room units can be placed anywhere. It is as efficient for modernization jobs as for new buildings. A room, floor, wing or whole building can be given year 'round comfort conditioning with American-Standard Remotaire without disruption of service or interruption of routine. Louvers fit flush against outside walls providing neat exterior appearance. Low room units fit beneath windows and may be installed in walls of any thickness from 8 to 20 inches.

For more information about this year 'round system that employs electricity, hot water or steam for the heating cycle, see your local American-Standard sales office or write AMERICAN-STANDARD, PLUMBING AND HEATING DIVISION, 40 West 40th Street, New York 18, N. Y.

classified advertising

POSITIONS OPEN

A & G MEDICAL—*Continued*

EXECUTIVE HOUSEKEEPER—298-beds; responsible directing and administering department, open to male or female, salary based on experience and potential, south.

PHYSICIAL THERAPIST—(a) Female; 350-beds; salary open, Ohio. (b) Male or female, all new facilities, 81-beds, salary open, west.

MEDICAL SOCIAL WORKER—189-beds, process expansion; to supervise social case work program; salary open, Ohio.

MEDICAL RECORD LIBRARIANS—(a) 100-beds and expansion, Chicago area, salary open. (b) Chief; 10 assistants, salary range $5,400 to $5,800, east. (c) Chief; 220-beds, full cooperation administration, salary open, Ohio. (d) 50-beds, ability to revamp department, registration not required, salary open, New York. (e) Area Los Angeles, large hospital.

NURSES—Anesthetists; (a) 200-beds, increasing staff from four to six, living quarters available minimum salary $500 plus all benefits, hospital will pay expenses for visit to interested applicants. (b) 669-beds and expanding, salary minimum $559 plus liberal benefits, midwest. (c) Small hospital, fully accredited, salary open, Arizona.

NURSE—School nurse; $425 month plus car allowance and additional amount for experience, west.

NURSES — FACULTY POSITIONS — SCHOOL OF NURSING; (a) Fall term, instructor for nursing of children and (b) Fundamentals of nursing, New Mexico, salary open. (c) Associate Director of nursing education and (d) Clinical instructor medical surgical nursing, NLA accredited school, salary open, Ohio. (e) Educational director and (f) Clinical instructor medical surgical nursing and (g) Obstetrical nursing instructor, 300-beds, salary open, Maryland. (h) Medical surgical clinical instructor and (i) Fundamentals of nursing and (j) Assistant director, school of nursing, 240-beds, salaries high, Texas. (k) Educational director and (l) Medical surgical clinical instructor and (m) Nursing arts instructor, 190-beds, salaries open, Mass. (n) Educational director and (o) Nursing arts instructor, 300-beds, salary for discussion, Virginia. (p) Director of N.S. and school of nursing, 168-beds, salary to $7,500 range, Pennsylvania. (q) Nursing arts instructor and (r) Medical surgical clinical instructor, 115-beds, salary open, midwest. (s) Clinical instructor who is also assistant director of nursing school; specialty hospital, salary $4,200, 4 weeks vacation after one year, 40 hour week, east.

NURSES—Director of Nurses; (a) Hospital located near resort area, salary for discussion, New Hampshire. (b) 135-beds with expansion program, college town, salary open, Pennsylvania. (c) 170-beds, salary commensurate with qualifications, plus apartment, Pennsylvania. (d) Director of Nursing administration; 368-beds, responsible for coordination of two departments under director of nursing education and director of nursing service; excellent background required; furnished apartment and full maintenance, salary open for discussion, south. (e) 70-beds; experience as supervisor in large hospital or assistant director of nurses in smaller hospital preferred, salary commensurate with ability and training, Arizona.

NURSES—Supervisors, operating room, obstetrics, staff; (a) O.R; 394-beds, salary open and go high for right person, Texas. (b) O.R; small hospital with affiliation University School of Medicine, new modern hospital, salary open, southeast. (c) O.R; large hospital, Los Angeles area, salary open. (d) OB; 115-beds, salary open, midwest. (e) OB; 250-beds; supervisor to assist with planning activities in new area, salary open, Ohio. (f) O.R; for new medical center, salary open, east. (g) O.R; R.N. with graduate experience in O.R; salary open, west (h) O.R; and 3-11 P.M. shift, 140-beds, salaries open, male or female, west.

NURSES—Listings for Operating Room Nurses, Los Angeles; (a) Surgical technicians, Los Angeles; (b) Staff nurses for day afternoon and night shifts, Los Angeles; (c) Staff nurses, Arizona; R.N. with surgical and obstetrical experience with full maintenance plus salary, Texas. (e) Staff nurses; small hospital with affiliation University School of Medicine, new modern hospital, salary plus perquisites and benefits, southeast. (f) 140-beds, salary open, male or female, west.

MEDICAL TECHNOLOGISTS AND TECHNICIANS—(a) 200-beds; ASCP, openings for two, salary and one meal, Kentucky. (b) Registered laboratory technician; small hospital, salary $350 plus payment for calls; Arizona. (c) ASCP, head technician; 92-beds, college town, salary open, New Mexico. (e) 100-beds; two qualified laboratory technicians; salaries open, Virginia. (f) 200-beds; female, capable becoming chief, salary open, New Jersey. (g) 85-beds, male preferred, qualified laboratory technician, salary open, New York.

(Continued on page 194)

Royal McBee is cutting hospital paper-work down to size

Up-to-the-minute reports on revenue analysis, patient-day and service-department statistics, patient billing, expense distribution. Reports that contribute markedly to better patient care. How to get them—without great cost or complexity? With the easy-to-use machines of the new Automatic Keysort System—today's most practical approach to data processing.

Automatic Keysort is today's *only* data processing system that provides for automatic creation and processing of original patient records. Speeding vital day-to-day and long-range facts essential to sound management, this unique system fits easily into your present operations . . . yet is highly flexible to future growth and expansion.

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Keysort Data Punch is located at nursing station, simultaneously imprints original records with patient information and code-notches them with statistical categories for rapid mechanical sorting into desired classifications.

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NEW CONCEPTS IN PRACTICAL OFFICE AUTOMATION

classified advertising

POSITIONS OPEN

A & G MEDICAL—*Continued*

(h) Combination laboratory and X-ray technician, salary open, Michigan. (i) 100-beds, expanding to 170-beds, prefer person with B.S. degree but not compulsory, male or female and will head department, salary open and many benefits included, south. (g) Male or female, prefer male, small hospital salary open, east. (h) ASCP, male or female to head department, large hospital, salary open, midwest. (i) Combination laboratory and X-ray technician, small hospital, salary open, Arizona. (j) Two experienced medical technicians; one should be male, salary open, Pennsylvania. (k) ASCP, small hospital with affiliation University School of Medicine, salary open, southeast. (l) 2 openings, ASCP, large hospital, salary open, Ohio. (m) Several openings; 600-beds; ASCP or replaced by education or experience 40 hour week, salary open, Ohio. (n) Chief medical technologist, prefer one who knows X-ray, 90-beds, salary open, Florida. (o) X-ray technician, Los Angeles area, salary open.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATIVE PERSONNEL — (a) Comptroller; east, within easy commuting distance of New York City; 175-bed hospital; $9500 up. (MH-3153). (b) Administrative assistant; California; capable of handling position of business manager in 250-bed teaching hospital; $7000 up. (MH-2848). (c) Assistant superintendent; east; 250-bed hospital; good background in business administration; to $7500. (MH-2938). (d) Director of volunteers and public relations; 250-bed teaching hospital, close to New York City. (MH-2807). (e) Credit and collection manager; middle west; 300-bed hospital. (MH-3131). (f) Personnel director; southwest; 400-bed hospital, 900 employes; department active in all areas of personnel, including training. (MH-3016). (g) Personnel and public relations director; east; 500-bed hospital; newly established position; good opportunity. (MH-2969).

DIETITIANS—(a) Therapeutic; middle west; 200-bed hospital, fully approved; $4800. (MH-3162). (b) Therapeutic; California; 250-bed hospital near San Francisco; $4800. (MH-3126). (c) Chief; middle west; 200-bed hospital within easy commuting distance of Chicago; 25 employes in dietary department; $6000. (MH-3034). (d) Food manager; man; south; 375-bed hospital; prefer hospital experience. (MH-2814). (e) Chief; east; 150-bed hospital; they have a decentralized dietary program and with help of new dietitian want to centralize; $6000 plus 3 room apartment and garage. (MH-2958). (f) Food supervisor; college for women; serve approximately 1200 family style. (MH-3006). (g) Assistant director for dietetics; will be responsible for a full half of dietary department, and must be capable of assuming complete charge of department at times; $7000 up. (MH-2968). (h) Administrative; middle west; 400-bed teaching hospital in beautiful resort area; $5400. (MH-2977).

SHAY—*Continued*

MEDICAL RECORD LIBRARIANS—(a) Assistant; middle west; 400-bed hospital, fully approved; $4800. (MH-3168). (b) Chief; California; new 130-bed hospital just opened; excellent opportunity; $5100. (MH-3169). (c) Chief; east; have just moved into entirely new 175-bed hospital building; $6000. (MH-3154). (d) Chief; suburb of Chicago; 250-bed hospital, 4 in department; $5400. (MH-3114). (e) Chief; east; large teaching hospital of well known university; real opportunity; top salary. (MH-3061). (f) Chief; west; 175-bed hospital in city of 40,000 that is rapidly becoming a medical center; hospital plans expansion and need someone capable of planning expansion of records departments; $5400. (MH-2917).

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR—(a) 120-bed eastern hospital; progressive community; $9,000. (b) 50-bed Iowa hospital. (c) 40-bed hospital, Virginia. (d) Small hospital, Upper Michigan. (e) Registered nurse; Convalescent home, New England.

ASSISTANT ADMINISTRATOR—(a) 300-bed Sisters' hospital, central states. (b) 275-bed Ohio hospital. (c) 300-bed teaching hospital, midwest. (d) 175-bed hospital, New York State; business management experience, preferred.

(Continued on page 196)

NEW A.C.M.I. STERILE PACKAGED

INFLATABLE CATHETERS

- Save nurses' time
- Eliminate autoclaving expense
- Reduce patient-care costs

Double protection

...double safety...

ready for instant use

The new A.C.M.I. Sterile Packaged Premium Catheter is double-protected by double packaging, for *assured* sterility. Even should the durable outer non-peelable package be torn or cut by unduly rough handling, the resilient inner peelable package still protects the sterile catheter from contamination.

Sterilization is achieved under rigidly controlled conditions; and is checked by thorough bacteriological testing before each lot is released. These catheters meet U.S.P. sterility standards and government specifications.

FREDERICK J. WALLACE, *President*

American Cystoscope Makers, Inc.

PELHAM MANOR, NEW YORK

classified advertising

POSITIONS OPEN

INTERSTATE — Continued

PURCHASING AGENT—(a) 375-bed hospital, Ohio. (b) Credit-collections manager; 285-bed hospitals, midwest; south. (c) Personnel Manager; director public relations; 375-bed eastern hospital. (d) Business manager; 100-bed Pennsylvania hospital.

DIRECTOR OF NURSING—(a) $6500-$7800; (b) Associate directors, nursing education; attractive positions. (c) 100-bed new hospital, Ohio; open fall.

TECHNICIANS—(a) Laboratory X-ray; small new Ohio hospital. (b) Laboratory; west; $400-$450. (c) X-ray; private clinics. (d) Pharmacists; To $7200.

EXECUTIVE HOUSEKEEPER—(a) 275-bed hospital, Pennsylvania. (b) 350-beds; mid western city. (c) 125-bed new hospital; Ohio. (d) 500-bed hospital, central states. (e) Laundry manager, $6000; east.

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES
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Mary A. Johnson, Ph.D., Director

FINE SCREENING
BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidates for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee
Agency

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A Specialized Employment Service for Medical and Hospital Personnel, (Men and Women.) For Administrators, Personnel Directors, Business Managers, Dietitians, Physicians, Director of Nurses, Therapists, Pharmacists, Medical Record Librarians, Anesthetists, Public Relations Directors, Housekeepers, Bacteriologists, Biochemists, Medical Technologists, X-Ray Technicians, Food Service Managers, All inquiries from applicants are kept strictly confidential.

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Every effort is made by careful confidential screening to select the best position for the candidate and the best qualified candidate for the position. Many of our clients request we do not give specific location or size bed information in our advertisement. WE DO INVITE YOUR INQUIRY. PHONE or WRITE US.

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We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Street, Chicago 12, Illinois.

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2-Caterpillar Diesel Electric Generator Sets 200 KW, 440V - 3 Phase - 60 Cycle. Powered by Caterpillar Model 375 Diesel engines, complete with floor type panel board with standard instruments and air starting equipment.

Generator Serial Nos. 55C8499 & 8500 Engines Serial Nos. 18B156 & 158 Less than 2800 hours operation.

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(Continued on page 199)

A New Hill-Rom Private Room Grouping

Sturdy . . . beautiful . . . inexpensive . . . many new pieces
All the modern innovations of our more expensive groupings
Suitable for nurses' dormitories, internes' rooms, etc.

● This new No. 9000 Grouping is built of Indiana Oak, finished in Honey Oak color. It was on this native Indiana hardwood that the Hill-Rom reputation for quality hospital furniture was built. This new grouping includes several items not before produced for hospital rooms, such as hanging wall closets, hanging wall cabinets and a bedside cabinet lamp—all designed to make possible fewer pieces on the floor. The result is rooms that are easier to clean, and give a less crowded effect. There are also several items that are equally suitable for nurses' dormitories, internes' rooms, etc.

Included in the room scene above are: No. 90-65 All-Electric Push-button Hilow Bed; No. 300 Safety Sides, No. 9003 Bedside Cabinet with No. 307 Lamp, No. 90-614 Overbed Table, No. 90-26 Chest Desk, No. 90-07 Straight Chair and No. 9008 Arm Chair. Catalog and complete information sent on request.

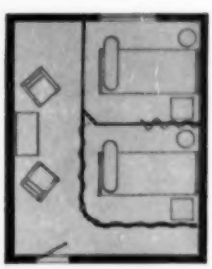
HILL-ROM COMPANY, INC. • BATESVILLE, INDIANA

(over)

HILL-ROM

"PERFECTED" CUBICLE SCREENING

. . . for wards, semi-private rooms, dressing rooms



private room convenience and appearance in semi-private rooms

Typical floor plan of suggested screening arrangement for semi-private room. Each bed can be entirely closed, thus giving both patients complete privacy—an advantage not obtainable with a single track installation.

Hill-Rom Screening gives privacy and convenience to semi-private rooms and wards. It does this without detracting from the appearance, as shown in the above picture. This bright, cheerful ward is completely equipped with Hill-Rom Screening, but when the curtains are not drawn the screening equipment is hardly noticed. No unsightly posts or pipes—no floor obstructions—maximum working area for doctor and nurse.

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Hill-Rom permanently flameproof Safety Curtains provide the utmost protection against fire, and are the ideal replacement for existing screening jobs. Even under intense fire the material in these curtains will not support a flame. It will only char. Even repeated launderings, with any type of soap or detergent, will not affect this flame-proof quality. Available in cream, peach, and green shades.

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HILL-ROM COMPANY, INC. · BATESVILLE, INDIANA

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

TRAINING FOR INSTITUTIONAL HOUSEKEEPERS. Two weeks intensive classroom followed by three months of supervised clinical training. Classes start September 28, applications accepted until September 1. For details, write: Vocational Director, Austin Vocational School, Austin, Minnesota.

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UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all techniques in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

ST. MARY'S HOSPITAL, Minneapolis, Minnesota, offers a fifteen month course in anesthesiology to graduates (men or women) of accredited schools of nursing. The course includes theory and experience in all phases of modern anesthesia. Enrollment dates February, May, August and November. Direct Correspondence to Director, Department of Anesthesia.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00 approved by the American Medical Association. For further information, write the director of Laboratories, Barnes Hospital 600 S. Kingshighway, St. Louis, Missouri.

SCHOOLS—SPECIAL INSTRUCTION

BARNES HOSPITAL: Offers an 18 month post-graduate course in Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met. Miss Helen Vos, R.N., B.S., Educational Director. Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, Barnes Hospital, St. Louis 10, Missouri.

"ANESTHESIA SCHOOL FOR NURSES, St. Joseph's Hospital, Lancaster, Pennsylvania, 18 month course AANA approved. No tuition. Stipend. Large clinical experience for students including great many endotracheal intubations. For complete details write Dr. N. Kornfield, St. Joseph's Hospital, Lancaster, Pa."

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

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Edited by BESSIE COVERT

WHAT'S NEW

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 229. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Convenient Ethi-Pack for Surgical Silk and Steel

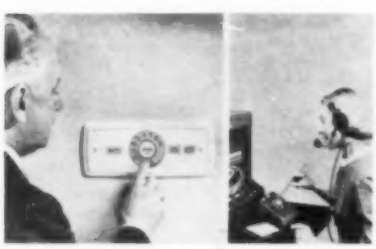
Developed for greater convenience and economy in the operating room, Ethi-

Packs® are two of six important new suture packaging developments recently introduced by Ethicon. Pictured are Ethi-Pack Surgical Steel, monofilament and multi-filament, packaged pre-cut in standard length strands, ready for autoclaving, and Ethi-Pack Surgical Silk Pre-Threaded to Straight, Taper Point Eyed Needles, specially developed for the surgical technic of closing the skin with pre-threaded eyed needles. Surgical Steel is packaged in envelopes of fifty 18-inch strands or thirty-eight 24-inch strands, sealed and ready for autoclaving, providing protection against bending or coiling. The silk is packaged with six individually sealed sutures in each section, ready for autoclaving, to be removed singly or all at one time, preventing kinked or tangled strands. **Ethicon Inc., Somerville, N.J.**

For more details circle #1 on mailing card.

"Dial-In" Doctors' Register Facilitates All Procedures

The new Auth fully automatic "Dial-In" system of doctor registration upon entering and leaving the hospital permits him to use any entrance. Equipped with a dial and three lamp-and-pushbutton combinations marked "In," "Out" and "Proceed," the



device permits the doctor to register no matter what entrance to the hospital he may use. On arriving he dials the number assigned to him and presses the "In" button. The information is automatically recorded and stored until needed. When the operator dials the doctor's number she instantly learns whether he is in or out, depending on the signal she receives. Time, space and effort are saved with the new system which is easy to install. **Auth Electric Co., Inc., Long Island City 1, N.Y.**

For more details circle #2 on mailing card.

Surgiderm Gloves Have Color Coded Bands

Surgiderm surgeon's gloves, formed to reduce hand fatigue by requiring less energy to flex fingers and hands, are now available with wrist band color codes to indicate glove sizes. The color-banded wrist supplements the original Surgiderm gloves with rolled wrist construction. **B. F. Goodrich Industrial Products Co., Sundries Div., 500 S. Main St., Akron 11, Ohio.**

For more details circle #3 on mailing card.

Easy Chair Has High Back for Patient Comfort

Comfort and support are provided for convalescent patients in the No. 6007 Easy

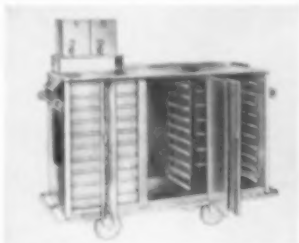
Chair introduced by Huntington. The loose cushions have removable covers for easy maintenance and sanitation, permitting their change between patients when necessary. The sturdy wood frame has Fawn or Acorn finish, but may be finished in special colors on order. **Huntington Furniture Corp., Hospital Furniture Div., Huntington, W. Va.**

For more details circle #4 on mailing card.

Food-ala-Cart System for Improved Food Service

"Diet Tray Confusion" is said to be eliminated with the new Nutting Food-ala-Cart System. Providing one oven drawer for every service tray, food assembly is simplified and accuracy assured. The frozen food section keeps frozen desserts frozen until served, even holding ice cubes without melting. All foods, whether hot or cold, are served at dietetically accepted temperatures. The beverage containers for carrying hot or cold drinks are nested into the cart when in transit to prevent the possibility of accident.

The interior of the cart can be easily changed to accommodate three different tray sizes, without the use of tools. It can also be adapted to handle from 16 to 24 trays and is readily cleared for steam cleaning. Doors open for full access to the in-



terior, with center hung door panels which do not extend beyond the cart when open. Large ball bearing wheels with non-marking rubber tires are especially compounded for easy starting and easy rolling. **Nutting Truck & Caster Co., Food Service Div., 1201 W. Division St. Faribault, Minn.**

For more details circle #5 on mailing card.

Electric Cooking Equipment in "Thunderbolt" Series

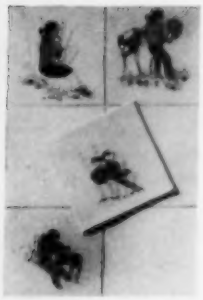
Designed to provide all counter cooking equipment required in hospital and other institutional kitchens, the new "Thunderbolt" Series of heavy duty electric cooking equipment includes fry kettles, large and "giant" griddles, hot plates and food warmers. All pieces in the line are available in stainless steel clad conventional free-standing units as well as in flexible, modern built-in units for customized kitchen installations.

The "Thunderbolt" fry kettles have safety controls to prevent overheating of grease no matter how long they are turned on. "Frying Guides" are permanently affixed to front panels with recommended frying temperatures in full view of the chef. The heavy-duty "Thunderbolt" griddles in two sizes have independent controls, permit-

ting the handling of various types of food at the same time, and have sufficient capacity for heavy institutional service. The hot plates and food warmers in the line have specially developed controls and all pieces are sturdily built for heavy-duty institutional service. **Toastmaster Division, McGraw-Edison Co., Elgin, Ill.**

For more details circle #6 on mailing card.

(Continued on page 204)



Curon Wallcovering Is Plain or Decorative

Attractive pastel and accent colors, or decorative tiles are available in Curon Wallcovering. The multi-cellular plastic has acoustical and thermal properties, is inert to bacteria, mold and mildew, and is fire-resistant. The durable, textured material is smooth, making it easily cleaned. It can be applied to any existing wall surface and protects walls with rough or cracked plaster. The easily-installed tiles are available in 10 or 20-inch squares, and the wallcovering is also available in 24 and 48-inch rolls. **Curtiss-Wright Corp., 30 Rockefeller Plaza, New York 20.**

For more details circle #7 on mailing card.

Portable Vacuum Cleaner Contoured to Fit Back

The new model ST-59 Strapavac Vacuum Cleaner, of molded high impact casing with aluminum trim, is contoured to fit the back comfortably in carrying and weighs only ten pounds. It may be converted quickly to an easy-wheeling floor model or powerful blower if desired and the one h.p. motor with Aera Cyclonic Action has strong suction power. A disposable paper bag inside the cloth filter bag permits constant air flow with no loss of suction until the bag is full. The versatile Strapavac has a variety of attachments for vacuuming all floors, carpets and walls in both crowded and open areas. **The M. D. Stetson Co., 64 E. Brookline St., Boston 18, Mass.**

For more details circle #8 on mailing card.

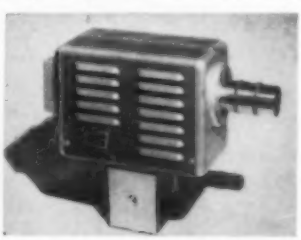
Ansul "D" Models in Dry Chemical Extinguishers

Four models are available in the new line of Ansul "D" dry chemical fire extinguishers. Featuring "fresh-fill" performance, including maximum fluidization, absolute gas tightness and simple operation, the new models include five, ten, 20 and 30-pound capacities. The line is entirely redesigned to achieve the modern functional look and the extinguishers are available in red or in white for maximum visibility in any location. **Ansul Chemical Co., Marinette, Wis.**

For more details circle #9 on mailing card.

Automatic TV Camera Is Self-Contained Unit

Model 63A Dage television camera is a completely self-contained unit which automatically accommodates a light range of 120 to one, and automatically self-adjusts beam, target and electrical focus circuits to optimum values. The lightweight unit is contained in a compact blue-gray hammertone case. It is one of the Dage Model 60 Series of Television cameras designed to provide a high degree of flexibility in use, simplicity of operation and minimum maintenance. **Dage Television Div., Thompson Products, Inc., Michigan City, Ind.**



For more details circle #10 on mailing card.

(Continued on page 206)

...x-tra value x-ray supplies

there's no delay the G. E. way

Dealing with General Electric is like owning your own complete warehouse of x-ray supplies. You get fast action on every order from any of 68 strategically located factory-operated offices.

No need for "scatter-buying" from several different sources. Get everything you need by "shopping" the complete selection of products listed in the G-E X-Ray Supply and Accessory Catalog.

Call your G-E x-ray representative *(he's listed in the yellow pages of your phone book)*. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin for Pub. H-76.

EXAMPLE:

Continuous cash savings—G-E SUPERMIX® film processing chemicals are today's *lowest-priced* quality solutions. Convenience packaged, too, in tough, knock-about plastic containers — developer, fixer, refresher and fixer-neutralizer in graduated polyethylene bottles that mix a gallon. (And so *lightweight* they're a joy to handle.)

Progress Is Our Most Important Product

GENERAL ELECTRIC

Sterilizable Cylinder for Silver Handling

The new RP-25 Economy Model cylinder for handling silver is made of rigid

polyethylene which is sterilizable and lightweight. The cylinders are available in white or steel gray color. They are used with the Steril-Sil System of silverware handling. Silver is washed with eating portions up in the cylinders, then tumbled into empty cylinders with eating portions down for protection until dispensed. **The Steril-Sil Co., 150 Causeway St., Boston 14, Mass.**

For more details circle #11 on mailing card.

Metal and Glass Doors Provide Fire Protection Unit

Metal and glass doors and frames to be used as smoke and fire screens in corridors are now available. The frames have been awarded a "C" label by Underwriters Laboratory, according to the manufacturer, and will withstand fire and smoke for 45 minutes. When the new units are installed in corridors in hospitals and other institutions, an area of refuge is provided, protected from smoke and flames. The frames may contain an opening for a door or pair of doors up to three feet six inches by seven feet for single doors and seven by seven feet for a pair of doors, and can be used with side lights and glazed transoms. **Overly Mfg. Co., Greensburg, Pa.**

For more details circle #12 on mailing card.

Variety of Top Arrangements in Garland Range Attachments

Model 10-27 is an 18 by 24-inch boiling plate operated by two three-heat

switches on a cabinet base. The 18-inch attachments are available in three top arrangements to fit every cooking use and are designed to fit beside the new line of Garland electric heavy duty ranges. Front and back halves of the Model 10-27 may be operated independently and the Model 10-28 has an all-purpose unit or griddle plate. The units are part of the comprehensive new line of ranges and attachments introduced in the Garland line. **The Welbilt Corp., Maspeth, N.Y.**

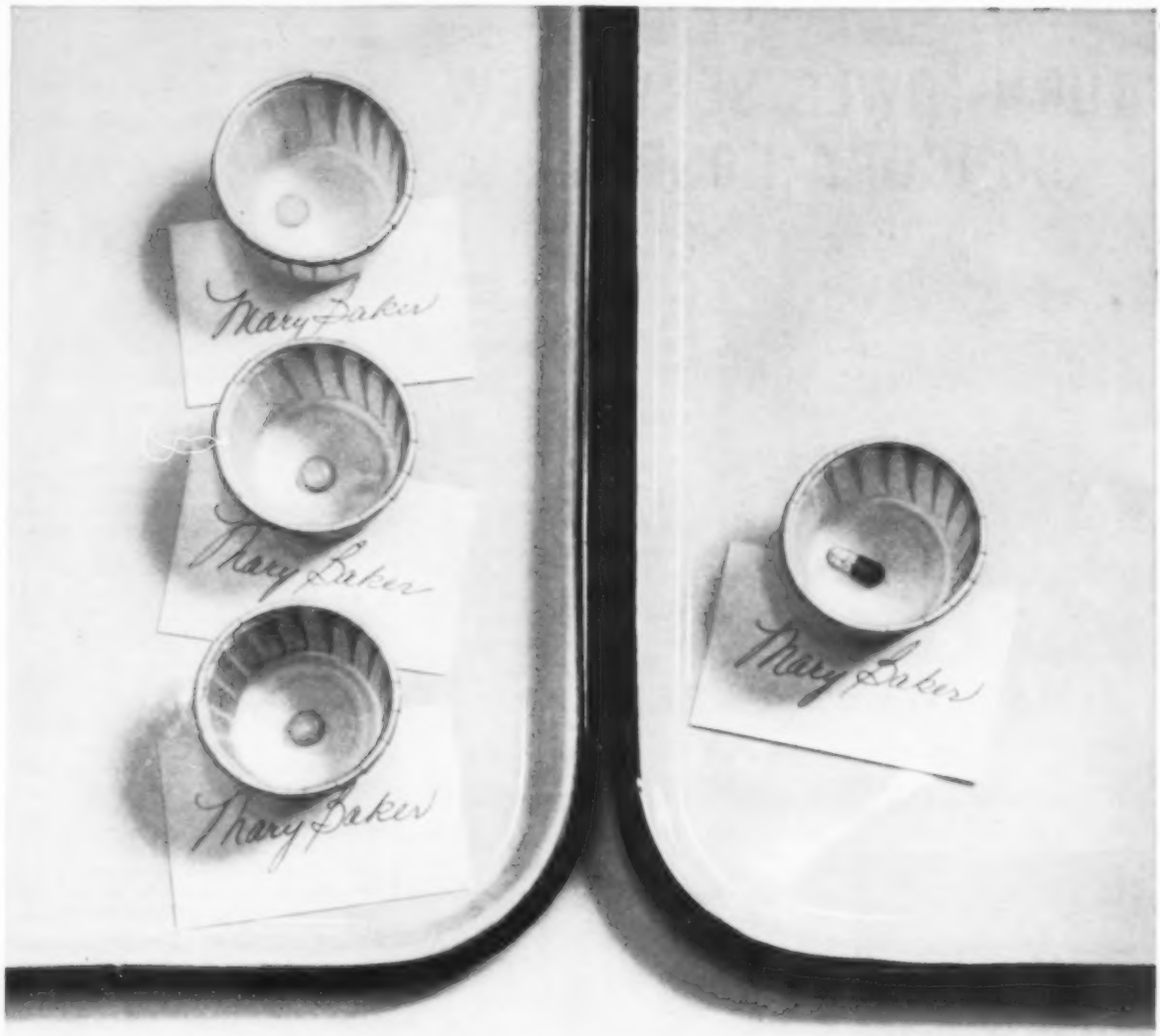
For more details circle #13 on mailing card.

Executive Quick-Call Offers Direct Line System

A compact, desk-top control cabinet at the master station of the new Type 11 Executive Quick-Call direct line system permits immediate connection with any one of as many as 20 preselected stations. The control cabinet, encased in modern "Trimline" metal wrap-around housing, has two rows of 11 translucent push-buttons across the front with designation strip in a holder between the rows. To place a call, the executive merely presses the appropriate button, lifts the handset of his own telephone, and a relay is activated to supply ringing current over the called line. The system speeds intercommunication and can be arranged to signal when a busy line disconnects. **Automatic Electric, Northlake, Ill.**

For more details circle #14 on mailing card.

(Continued on page 208)



Why should the nurse make three trips when she can do the job in one?

Only one trip with Spansule® brand sustained release medication is necessary because a single oral dose provides prompt therapeutic effect that lasts all day or all night long. Trials with 'Spansule' capsules in a 318-bed hospital led to this comment by the Chief of Medical Service[1]: "The marked decrease in both the number of visits needed to distribute the medication and the amount of effort needed to prepare it for distribution saved valuable time for the institution's personnel."

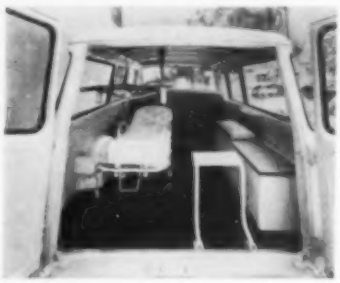
Your local S.K.F. representative will be glad to discuss with you the advantages of 'Spansule' medication (including price).

Smith Kline & French Laboratories, Philadelphia first ⧗ in sustained release oral medication

1. Messeloff, C.R.: Hospitals 29:122.

Small Ambulance Has All Equipment

The new International ambulance is a small, practical unit which is furnished



with invalid cot, folding overhead litter, padded longitudinal seat and folding rear step. The double rear doors allow easy access to the patient area. The units are low in cost and can accommodate two patients at one time for emergency or disaster work. **International Harvester Co., 180 N. Michigan Ave., Chicago 1.**

For more details circle #15 on mailing card.

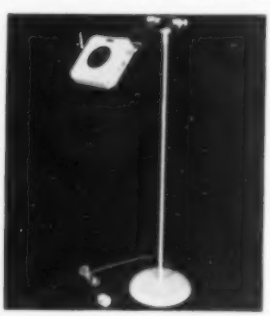
Aspirator Bottles in Eight Sizes

Eight different sizes, ranging in capacity from one-half to 25 liters, are available in the three types of Aspirator Bottles now available from Mercer Glass Works. One type has the bottom especially tooled for rubber tubing, the second type for both cork and rubber stoppers, and the third type for glass stoppers. The hexagon-shaped glass stoppers are designed to prevent rolling and breakage while giving a firm grip. All three models are mold blown for uniformity and have wide, flat bases and clear heavy walls. **Mercer Glass Works, Inc., 725 Broadway, New York 3.**

For more details circle #16 on mailing card.

Illuminated Examining Magnifier in White Floor Model

Improved lens sections are incorporated into the new Models 1207 and 1208 floor

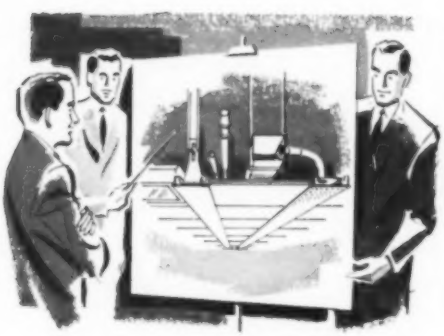


model illuminated magnifiers for examinations and laboratory work. Available with single or double lens, the magnifiers have a plastic housing with a high finish aluminum inner reinforcing which also holds the circline tube clamps. The compact unit, with fluorescent, shadow-free indirect light surrounding the lens, gives excellent magnification for careful examination of patient or specimen. **The Larrimore Co., P.O. Box 1234, St. Louis 1, Mo.**

For more details circle #17 on mailing card.

(Continued on page 210)

Ceilings That Never Go "Off Duty"!



Whether you are building, expanding, or modernizing, you'll want your hospital to have modern acoustical ceilings that not only provide sound conditioning, but also can be planned to incorporate air conditioning, lighting, and concealment of utility lines.

To help you plan the one right combination of products and installation methods for your hospital, your Acousti-Celotex Distributor offers expert Ceiling Consultation Service, without obligation.

Because he is a member of the world's largest acoustical organization, you get the benefits of technical skill and product superiority resulting from 34 years of Celotex leadership in the field of sound conditioning. Send coupon below today!

SHOWN: New 2' x 2' Random® Perforated Incombustible Mineral Fiber Tile. Just one of many types of Celotex acoustical products.

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Please send me your free booklet "The Quiet Hospital" and name of my nearest Acousti-Celotex Distributor.

Name _____ Title _____

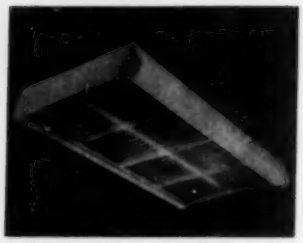
Hospital _____

Address _____

City _____ Zone _____ State _____

For additional information, use postcard facing Cover 3.

Hector Lighting Fixture in Contemporary Design



Developed for use in offices, and other areas with critical seeing problems, the new Hector lighting series employs the Holophane Prismalume lens for superior brightness control and efficiency. The side panels produce low contrast with the ceiling and lens for maximum seeing comfort. The contemporary design of smooth curved lines makes the Hector attractive. **Lighting Dynamics, 802 W. Whittier Blvd., Whittier, Calif.**

For more details circle #18 on mailing card.

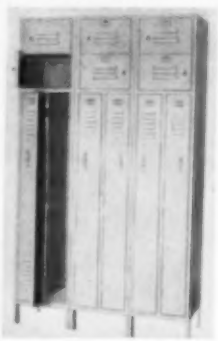
Seasonmaker Room Conditioners Have Modern Styling

Modern, compact styling makes the new line of Seasonmaker individual room air conditioning units occupy minimum room space. Only 8½ inches wide and 25 inches high, the four new models are each available in five sizes. They are designed for ceiling, floor, hide-away and basic installations, with heating and cooling capacities of 220, 330, 440, 520 and 640 cfm. Individual room comfort at any desired temperature levels are provided, including heated, filtered air in winter and cooled, dehumidified and filtered air in summer. **McQuay, Inc., 1600 Broadway St., N.E., Minneapolis 13, Minn.**

For more details circle #19 on mailing card.

Two-Person Steel Lockers Serve Two in Space of One

Designed to provide full-height compartments for two persons in the same area required for one large individual locker, the



new Penco two-person steel lockers have separate, full-width hat compartments. The half-width lockers have new design and construction features including tamper-proof door handles, twist-resistant door frames and full-loop door hinges. They are equipped with coat hooks, coat hanger rods, door number plates and ventilating louvers. Each lower door controls one of the hat compartment doors by an interlocking device. **Penco Div., Alan Wood Steel Co., 200 Brower Ave., Oaks, Pa.**

For more details circle #20 on mailing card.

Stainless Steel Cabinet for Mobile Dish Dispenser

The AMF Cup and Saucer dispenser for mobile handling of cups and saucers now

has a seamless, welded stainless cabinet for improved appearance, sturdy construction and ease of cleaning. The mobile unit eliminates the need for rehandling cups and saucers between dishwasher and server and has a capacity of up to 12 dozen cups and saucers. They are dispensed at cabinet top level and the tube-dispensing mechanism has one simple knob-adjustment at the bottom which is set for the proper level. **American Machine & Foundry Co., Lowerator Div., 261 Madison Ave., New York 16.**

For more details circle #21 on mailing card.

(Continued on page 214)

the most versatile conveyor ever built!

New Variable Capacity FOODVEYOR serves either 18, 20, 22 or 24

Now one food conveyor, the new Blickman Foodveycr, has the versatility of four, thanks to Blickman's exclusive new concept of "variable capacity". Now the cold compartment can be adapted to serve any number of patients from 18 to 24. Capacity increases or decreases simply by changing sets of non-tilt tray racks. Your conveyor load is governed only by your own weekly or daily feeding requirements. And that's not all. Here are just a few of the other advantages you get with the exclusive Foodveyor:

- *Mechanical forced air refrigeration system cools instantly to 40°.* ¼ hp compressor cools faster than your refrigerator. Does away with need for cold plates, deep freezers or pre-freezing.
- *Spacious heated compartment.* Fully insulated heated compartment contains 8 easy-glide drawers with room on each for 3 nine-inch dinner plates and 3 bouillon cups. Thermostatic control keeps cooked foods oven-fresh and piping hot.
- *Stainless steel construction for lifetime service.* Foodveyor is constructed of stainless steel inside and out. Tray slides and heated drawers are fabricated of heavy gauge lightweight aluminum.

Only Blickman makes the revolutionary new Foodveyor. For full information see your Blickman dealer or write S. Blickman, Inc., 1507 Gregory Avenue, Weehawken, New Jersey.

SEE US AT: American Hospital Show
New York Coliseum
Booth: 1428
August 24-27, 1959

BLICKMAN
FOOD SERVICE EQUIPMENT

Look for this symbol of quality Blickman-Built

3 Colgate Hospital Products for Outstanding Performance and Welcome Economy

COLGATE COLEO

Laboratory Glassware and Surgical Instrument Cleaner

For laboratory and surgical equipment . . . cleanliness begins with COLEO! COLEO *dissolves* quickly, *cleans* thoroughly, *rinses* freely. Its efficient blood-removal action makes it especially desirable for cleaning surgical instruments and other O. R. and laboratory equipment.

Packed in 50 and 100-lb. Fibre Drums and 5-lb. Cans (6 per case). Write for prices.

COLGATE ARCTIC

Hexachlorophene Surgical Liquid Soap U.S.P.

Highest quality. Conforms to U. S. Pharmacopeia requirements when diluted as directed. Contains special ingredient to prevent clouding and formation of precipitates when diluted with 2 parts hard water (up to 300 PPM). Excellent lathering qualities.

Rinses quickly. So *mild* and *gentle* you can use it on your face!

Available in 30 and 55-gal. Drums and in 5-gal. Pails. Write for prices.

COLGATE BEAUTY WHITE

Made To Order For Hospital Use

Colgate Beauty White meets rigid hospital requirements because it is *made especially* for hospital use. Hard milled for utmost economy, this mildly fragrant bath soap gives *abundant lather* in all types of water. Next time, specify Beauty White. Your patients will appreciate it—and you'll *save money!*

Two sizes packed unwrapped. Also one size available wrapped. Write for prices.

FREE! Latest Edition Handy Soap and Synthetic Detergent Buying Guide. Tells you the right product for every purpose. Ask your C.P. representative for a copy, or write to our Associated Products Dept.

COLGATE PALMOLIVE CO. CP QUALITY PRODUCTS SINCE 1806 A SYMBOL OF QUALITY FOR OVER 150 YEARS

COLGATE-PALMOLIVE COMPANY

300 Park Avenue, New York 22, N. Y.

Atlanta 5, Ga. • Chicago 11, Ill. • Kansas City 11, Mo. • Oakland 12, Calif.

AT CHICAGO WESLEY MEMORIAL—

12 SCOTSMAN ICE MACHINES

Save Steps, Save Labor, Cut Costs!

Nurse aide easily scoops out flaked ice from waist high bin of Scotsman Super Flaker ice machine. Note compact size.

Almost every floor at Chicago Wesley Memorial Hospital is equipped with a modern Scotsman ice machine!

In this up-to-date 700 bed hospital, 12 Scotsman ice machines solve many problems. Formerly, the hospital had its own central "ice house" where ice was frozen and shaved. Now Scotsman Flakers and Cubers provide a dependable "every floor" source for crystal clear, pure ice. There is no danger of contamination—ice does not have to be touched by hand! Waste of ice supplies is virtually eliminated and savings are "appreciable," officials say.

From 11 diet kitchens on patient floors, Scotsman Super Flakers provide ice around the clock. Ice is used constantly for ice packs, body swellings and the patient's general comfort. Beverages are chilled and fruits and salads are bedded in ice. An additional Scotsman Super Cuber provides big, round, ice cubes as required.

Scotsman ice machines have earned the approval of Wesley officials and many other hospitals executives as a dependable source of pure ice that costs as little as 8¢ a hundred pounds. If you use ice in quantity, you need Scotsman ice machines.

Clean, pure Scotsman ice is always available for use in ice bags and for other patient needs at Chicago Wesley Memorial Hospital.

Scotsman Super Cubes efficiently chill milk cartons in the hospital cafeteria. Cubes are big, round, solid for long cooling.

A bed of Scotsman Super Flakes keeps salads crisp, cold, attractive in the Chicago Wesley Memorial hospital cafeteria.

SCOTSMAN

AUTOMATIC ICE MACHINES

World's Largest Line • World's Largest Seller

Make your own SCOTSMAN ice for as little as 8¢ per 100 lbs! Send for FREE 44-page booklet, "How To Use An Ice Machine."

NAME_____

ADDRESS_____

CITY_____ STATE_____

MAIL TO: **SCOTSMAN ICE MACHINES**
Queen Products Division, King-Seeley Corporation
97 Front Street, Albert Lea, Minnesota

EXPORT OFFICE: 15 Williams St., New York, N. Y.

Silmfin Fixtures for Efficient Lighting

The extra slim, swept-wing design of the new Slimfin fluorescent luminaire with Finglow light beams gives a soft uplight while providing highly efficient downlight. The Finglow side wing edges are molded of polystyrene plastic and the fixtures are finished in White Permalux with chrome end fins. Slimfins are available with Gratelite Louver Diffuser and Prismoid Gratelite or Metal Cross Baffle bottoms. They are designed for close ceiling or pendant mounting, in individual or continuous row installations. **Edwin F. Guth Co., 2615 Washington Blvd., St. Louis 3, Mo.**

For more details circle #22 on mailing card.

Hypostainless Needles in Full Specialty Line

A full line of Hypostainless Specialty Needles is now available. Featuring chrome-plated brass hubs, Hypostainless steel cannula and special sharpness for smooth penetration, the line includes needles for practically every specialty use in stock for immediate delivery. Any needle may be ordered and made to specifications. **Hypo Surgical Supply Corp., 11 Mercer St., New York 13.**

For more details circle #23 on mailing card.

Automatic Tray Dispenser Holds 90 to 150 Trays

Ninety to 150 trays can be dispensed at any desired height in the new Serv-O-Lift Tray Dispenser. A removable handle which fits into a recessed socket on the front of

the dispenser is turned to change the dispensing level instantly to any desired height. A stainless steel carrier maintains the trays at the dispensing level and a stainless steel aircraft cable control keeps them in perfect alignment. There are no openings or projections in the cabinet interior to accumulate dirt and bacteria.

The Serv-O-Lift Tray Dispenser is available for in-counter installations or as a mobile unit for transporting as well as dispensing, heated or unheated, in sizes to fit all operations. **The Serv-O-Lift Corp., 1205 Dorchester Ave., Dorchester 14, Mass.**

For more details circle #24 on mailing card.

Unit Ventilator Heats and Cools

Quiet, trouble-free operation in providing heating or heating and cooling with a

large range of capacities is offered in the new Praetorian unit ventilators. They are available in two sizes, with three coil arrangements each, and have permanently lubricated bearings, hard anodized dural shaft and graphite-impregnated nylon bushings in all moving parts. A new principle of air blending gives efficient operation, utilizing aerodynamics discs moving axially along a shaft within blower wheels. One side of each blower assembly can draw only fresh air, the other side only heated or cooled air. **Valveblower Co. of California, Inc., 13725 E. Rosecrans Ave., Santa Fe Springs, Calif.**

For more details circle #25 on mailing card.

(Continued on page 218)

You Can See and Feel the Difference!

See the smooth finish of these Carolab cotton balls . . . feel the firmness, too. This is virgin long-staple cotton, carefully spun so that there are no nibs, no loose wispy ends. Carolab cotton balls are soft, yet with proper density for greater absorbency.

There is a complete range of sizes—five to meet every need in the hospital . . . from nursery to accident ward, from pharmacy to blood bank and laboratories.

Carolab cotton balls are economical, too. They replace sponges in many hospital procedures to provide improved technic as well as lower cost. You will find Carolab is truly a better ball at a lower price.

Manufactured Where Grown

super	2000 per case	
special	2000	special is same size as large but is almost twice as dense
large	2000, 4000	
medium	4000, 8000	
small	8000	

rayon balls also available in the four larger sizes, same packing and price

On request, a large sample case of the complete line of Carolab surgical dressings will be delivered for inspection by OR, OB and CRS supervisors, purchasing agent or business manager, and other interested hospital personnel.

CAROLINA ABSORBENT COTTON CO.
(Division of Barnhardt Mfg. Co., Inc.)
P.O. 2176 **Charlotte 1, North Carolina**

Carolina your dependable source

for All Hospital Textiles . . .

- BATHMATS
- BASSINET LINERS
  - *pads*
  - *padding*
- BEDSPREADS
- BLANKETS
  - *Bath*
  - *Crib*
  - *Ether*
- CURTAINS
  - *curtain material*
- DRAPERY MATERIAL
- LAUNDRY FELT
- LINEN MARKERS
- MATTRESS COVERS
- PIECE GOODS
  - *white and colored*
- PILLOWS
- PILLOW CASES
- PILLOW COVERS
- SHOWER CURTAINS
- SHEETS
  - *BED*
  - *CRIB*
  - *bleached*
  - *unbleached*
  - *percale*
  - *contour*
- SHEETING
  - *bleached*
  - *unbleached*
  - *jade green*
- TAPE
- TABLE LINENS
  - *tablecloths*
  - *napkins*
  - *tray covers*
- TICKING
- TOWELS
  - *terry*
  - *huck*
  - *absorbent*
  - *kitchen*
  - *name woven*
- TOWELING
- UTILITY FABRICS
  - *drill*
  - *twill*
  - *duck*
- WASH CLOTHS

HOSPITAL INDUSTRIES ASSOCIATION HIA

Whatever your needs—from a wash cloth to a bolt of drapery material—Carolina has it or can get it. **Your textile problems are our business.**

More important, Carolina has in stock a complete selection of grades—from service weights to luxury items, unbleached muslin to percale—to meet your individual requirements, *and your budget!*

A Carolina representative will be glad to show you samples, help you in any possible way.

Send for a complete Carolina catalog if you do not have one readily available—14-page section on textiles included.

IMPORTANT: Carolina carries only *branded* merchandise—your guarantee of dependable uniformity. High tensile strength, long wearing characteristics are inherent in products bearing the maker's own name.

ROLA
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Carolina Absorbent Cotton Co.

(Division of Barnhardt Mfg. Co.)

CHARLOTTE 1, NORTH CAROLINA

quality products of cotton since 1900

Having HARD WATER Troubles?

LAUNDRY

Dingy linens...undue replacements... costly washroom supplies

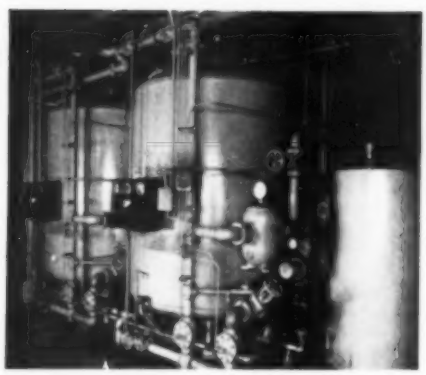
KITCHEN

Dulling film on dishes and glassware ...excessive dishwashing compounds

SERVICES

Scale clogged boilers, water heaters, piping and other equipment...excessive maintenance.

Time to let us modernize your water softener



Typical double-unit Elgin Automatic Water Softener. Other types from small to largest; manual, semi-automatic, fully automatic.

Hard water has a way of sneaking up on you. It shows up in dull, unappetizing glassware and dishes...in graying, shabby looking laundered articles...in scummy and discolored fixtures...in fouled sterilizers. It takes its toll in big bills for washing preparations ...in shortened life of linens...in excessive costs of maintaining equipment...just to name a few of the many trouble spots.

If you are running into these troubles, chances are your water softener has reached the stage where it either has to be fixed up or replaced...and putting it in good shape may cost you far less than you think. Often just refilling it with new improved zeolite will restore it to full efficiency. Sometimes inexpensive alterations will give it new life. But even if it needs replacement, the cost will be far less than the dollars you will save by getting rid of your hard water troubles.

And whether it's modernization or replacement, Elgin with more than 50 years experience in the water conditioning field has proved ideally qualified to give you the most efficient, most economical answer to your problem.

Coupon brings new bulletin

Our new Bulletin 615 tells how simply we can modernize any basically sound softener. Also describes our newest manually and automatically operated water softeners. Mail the coupon for copy.

ELGIN
WATER CONDITIONING
SINCE 1908

ELGIN SOFTENER CORPORATION
144 N. Grove Ave. • Elgin, Illinois
Representatives in principal cities
In Canada: G. F. Sterne & Sons Ltd., Brantford

Send me your new Bulletin 615

- ☐ If checked have your representative contact me
- ☐ Interested in modernizing present softener
- ☐ Interested in new water softener

Name_____

Street and Number_____

City_____ State_____

By_____

Mail to Elgin Softener Corp., 144 N. Grove Ave., Elgin, Ill.

Velvetex Floor Covering Is Easily Cleaned

A new foam rubber floor covering with a tread surface of tough patterned vinyl which is easily cleaned is introduced in Dupont Velvetex. The cushioned flooring is soft to the step yet has high wear resistance. It can be vacuumed, swept, wiped or washed clean since dirt does not penetrate the vinyl top side. Strong fabric reinforcement will hold tacks. **E. I. du Pont de Nemours & Co., Room D-5033, Wilmington, Del.**

For more details circle #26 on mailing card.

Kel-Win Leaknot Faucet Closes Automatically

A new patented principle built into the Kel-Win Leaknot Self-Seating Faucet closes it automatically to form a positive

and permanent seal. The faucet operates by a cam and straight-lift piston action. It remains open at any desired water flow, leaving both hands free, but the final closing and seating are automatic. The user starts the closing operation by hand but before a half turn is accomplished a spring takes over to close or seat the valve and, at the same time, water pressure pushing up against the bottom of the valve applies pressure and prevents leakage. There is no way for manual pressure to be applied on washers or seat and the Kel-Win is constructed for maintenance-free use. A life expectancy test conducted on the new faucet showed it to open and close easily, with complete shut-off when the valve was closed, after the equivalent of 100 openings and closings a day for over 27 years. **Kel-Win Mfg. Co., 3021 W. Clay St., Richmond 30, Va.**

For more details circle #27 on mailing card.

14-Inch Duplicator Added to Ditto Line

The third in the series of D-70 office duplicators brought out by Ditto is a 14-inch model which takes paper from three by five inches up to 14 by 14 inches in size.

As with the other new D-70 models, the machine has longer, lower and wide styling than earlier models and is finished in a combination of sand gray and green. New engineering features for increased versatility in both general duplicating and business systems use are built into the new line.

Features of the new model include pushbutton intermittent paper feed, fully adjustable feeding and receiving trays that eliminate the need for auxiliary guides or feeding attachments, a two-in-one control lever permitting the operator to open the master clamp with one motion, then close it and start the machine with another, and a knurled wheel in the drum for positive registration of master to copy paper, among others. **Ditto, Inc., 6800 McCormick Rd., Chicago 45.**

For more details circle #28 on mailing card.

Contact Bond Cement Is Non-Flammable

Essentially odorless and non-hazardous, Formica Safe-Bond contact bond cement is non-flammable. The new adhesive is designed for wall application of plastic laminates, in woodworking and for remodeling of counters and tables. Formica Safe-Bond can be brushed, rolled or sprayed, is convenient and easy to work with and has no noxious odor. **Formica Corporation, 4614 Spring Grove Ave., Cincinnati 32, Ohio.**

For more details circle #29 on mailing card.

(Continued on page 222)

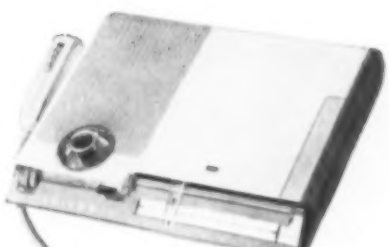
1:40 A.M. –but Voicewriter's on duty for dictation!

No SECRETARIES AROUND at this time of night . . . but the surgeon has only to pick up that phone to dictate his postoperative report while it's fresh in his mind. The phone is one of the dictating stations in the hospital's Edison Televoice system that helps keep records up to date.

What a blessing to your busy staff! Doctors can keep their reports up to date with half the effort. No waiting for a secretary to take dictation . . . or valuable time spent in writing longhand reports. And Voicewriter is easy for visiting doctors to use, without complicated instructions.

Boosts productivity of records personnel, too! No problems deciphering doctors' written reports. No hours of shorthand. With Voicewriter, medical secretaries just transcribe from the Edison Diamond Disc. The doctor's voice comes through clearly. Backlogs of reports are eliminated.

Where should you use Voicewriter? Station this dependable dictating facility at every point where records originate . . . in your surgical suites, doctors' offices, nurses' stations, clinic rooms, pathology labs, radiology. That's how Voicewriter can assure you complete, accurate, up-to-date medical records.



Take the mike of this all-new VOICEWRITER! See why it's the finest dictating instrument ever built. For a free tryout—or for literature—write Medical Dept. MH-7 at the address below.

Edison Voicewriter

McGRAW EDISON

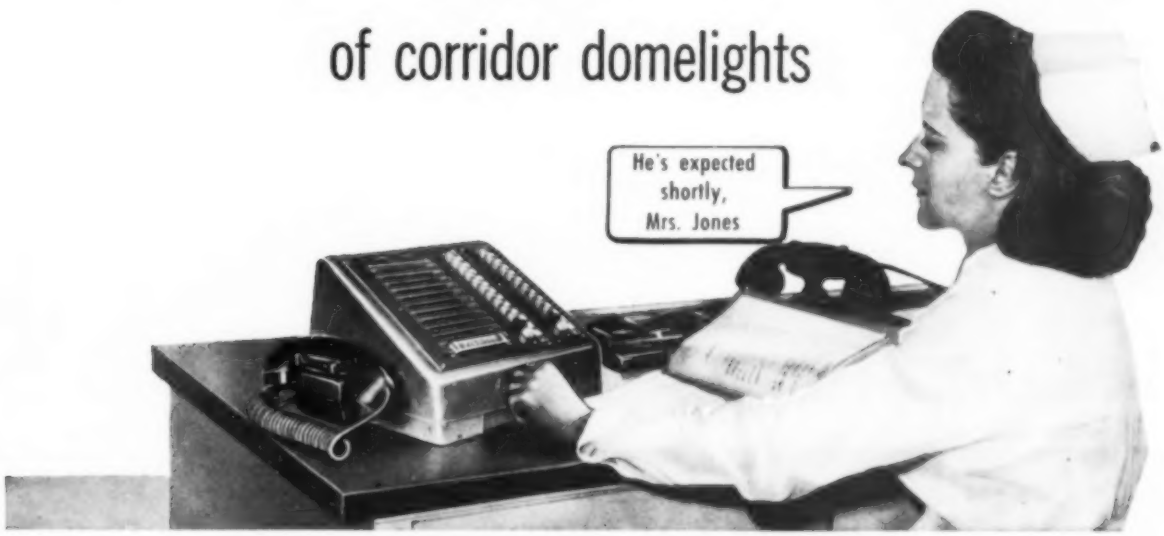
A product of Thomas A. Edison Industries, McGraw-Edison Company, West Orange, N. J. In Canada: 32 Front Street W., Toronto, Ontario

Add **AUDIO** easily

to your present

VISUAL nurse call system

of corridor domelights



Executone's DEPENDABLE Audio-Visual Nurse Call System Cuts Foot Travel in Half!

Easily and quickly added to your present visual domelight system, Executone frequently uses *existing* conduits or raceways—providing you with a *modern* Audio-Visual Nurse Call System! All accomplished with no interruption of service during installation!

Many hospitals—old and new—are discovering the economy and efficiency of Executone's Audio-Visual system. More patients are handled with *less effort, in less time!* One hospital reports that Executone has reduced operating costs 3% per bed. *It is an invaluable aid in relieving the nurse shortage.*

By pressing a bedside button, the patient activates signals at three locations—chime and light on nurse's control station, corridor domelight, buzzer and light on duty stations. The nurse presses key to reply . . . Executone's Call System may be installed complete, added to existing domelight systems, or installed without domelights.

Just off the press!

"Better Patient Care"

How Executone communications help hospitals improve patient care and make maximum use of nursing time and skills. Includes a summary of time and motion studies of Executone Audio-Visual Nurse Call Systems made by the Surgeon Generals' offices of the Army and Air Force. Also described and illustrated are Doctors' Paging Systems, Bedside Radio-Sound Systems, Departmental Administrative Systems. Send in the coupon below for your complimentary copy.

Executone

HOSPITAL COMMUNICATION SYSTEMS

MAIL COUPON TODAY!

EXECUTONE, INC., Dept. 3-6 415 Lexington Ave., New York 17, N.Y.
Without obligation, please send me a complimentary copy of "Better Patient Care."

Name_____ Title_____

Hospital_____

Address_____

City_____ State_____

In Canada: 331 Bartlett Avenue, Toronto

Polyester Film for "Boil-In-A-Bag" Cookery

The cooking of special servings or fresh preparation of small quantities of foods is now possible with the "boil-in-a-bag" method of cookery. Cooking of small quantities in packages is made possible through use of "Scotchpak" polyester film No. 20A5 developed by 3M. Specially designed for the purpose, "Scotchpak" will be used by food processers, making vegetables and other foods available for "in-a-bag" cooking. A laboratory report on the process is available from **Minnesota Mining & Mfg. Dept. TS-332, 900 Bush, St. Paul 6, Minn.**

For more details circle #30 on mailing card.

Automatic Parking System Is Coin-Operated

No attendants or meters are required for controlled parking with the new Parcoa coin-operated automatic parking system. The automatic gate is operated by elec-

tronic controls which are activated by the insertion of a coin, or coins, in a slot. The coin collector adjusts to any rate from five cents to $1.35 and can be coin or token operated. Features of the coin box include a self-locking cash vault and a capacity counter to prevent opening of the gate when the parking area is filled. The gate closes when the car passes over the treadle. **Parcoa Div., Johnson Fare Box Co., 4619 N. Ravenswood Ave., Chicago 40.**

For more details circle #31 on mailing card.

Vibroflotation System for Building on Sand

A foundation system for buildings which must be constructed on sand is described as Vibroflotation. It is a compacting service which eliminates the need for pilings and transforms sand into a compact, uniform mass, capable of supporting the heaviest loads. The compaction results from the simultaneous vibration and saturation of a granular soil by a Vibroflot machine. It is achieved by removing the voids between particles through rearranging the grains of sand into a tight mass throughout the desired depth of the area involved, producing a firm foundation on which any kind of light or heavy structure can be built. The machine produces cylindrical compacted sand columns for a foundation. **The Rust Engineering Co., 930 Fort Duquesne Blvd., Pittsburgh 22, Pa.**

For more details circle #32 on mailing card.

Panic Exit Device Has Covering Trim

A special escutcheon trim designed to cover holes and marks left on doors in remodeling is part of the new Yale panic exit device. Time and money are thus saved when mortise locks are removed from exterior doors in old buildings and the new fast and safe exit device is installed.

The old door need not be replaced or extensively refurbished as the new escutcheons completely and decoratively cover most defacements when the device is installed. A firm touch on the horizontal bar of the device, which extends the full width of the door, opens it immediately, assuring instant exit in an emergency. **The Yale & Towne Mfg. Co., 11 S. Broadway, White Plains, N.Y.**

For more details circle #33 on mailing card.

Highly Finished Metal Surfaces Cleaned With Formula No. 875

Emollients for extra mildness and safety for high finish surfaces are included in Formula #875, a free flowing liquid cleanser for stainless steel, monel and other highly finished metal surfaces. Oily dirt is emulsified and heavy, insoluble dirt is removed with Formula #875. It comes in a re-usable 12 oz. squeeze bottle. **Bar-Ray Products, Inc., 209 25th St., Brooklyn, N.Y.**

For more details circle #34 on mailing card.

Professional-Type Copy Prepared With All-Purpose Scope

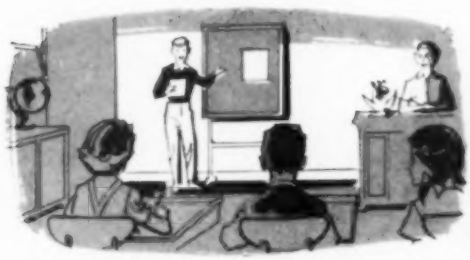
The new Superscope is an all-purpose device to facilitate the preparation of professional-type material for duplicating processes. It is designed to provide the proper

surface and light for drawing, lettering, ruling and writing on all stencils, spirit and gelatin masters and paper offset plates, and can be used as a light table for retouching negatives. The Superscope is portable, easy to handle, and folds compactly for storage. It can be used in a standing position with all four legs extended, or in a seated position with the front legs folded under. It features an adjustable light, sliding T-square, and spring steel clamps to hold material, among other advantages. **The Heyer Corp., 1850 S. Kostner Ave., Chicago 23.**

For more details circle #35 on mailing card.

(Continued on page 224)

NEW Sanitized®

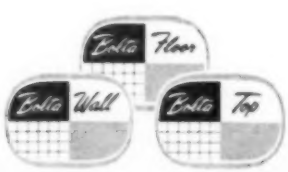


SCHOOLS, COLLEGES, NURSERIES

HOSPITALS, CLINICS, LABORATORIES

HOTELS, MOTELS, RESTAURANTS

OFFICES, THEATRES, STORES



A decorative durable vinyl for every purpose

Bolta Wall®

VINYL WALL COVERING

The best way to baffle bacteria

Sanitized Bolta-Wall is:

BACTERIA AND GERM RESISTANT—Retards, resists and inhibits the growth and action of bacteria and germs.

ODOR RETARDANT—Acts to prevent and resist odors.

FUNGI, MOLD, MILDEW, AND ROT RESISTANT—Retards growth and action of these micro-organisms.

NON-TOXIC AND NON-IRRITATING

HYGIENIC AND ANTISEPTICALLY CLEAN

Insist on this important feature. Now ***exclusive*** *with Bolta-Wall in the vinyl wall covering field*

For complete information write:

THE GENERAL TIRE & RUBBER COMPANY
BUILDING MATERIALS DIVISION • AKRON 9, OHIO

Double-Face Coat Rack in 12 and 24 Capacity

Two sizes are available in the new double-face coat rack introduced by Lyon. It supplements the complete line of single-

face and wall type coat racks manufactured by the company. Current single-face racks can be readily converted to double-face with a low-cost conversion package recently developed. The racks are available in 12 and 24 capacity models, with polished hardwood hangers. **Lyon Metal Products, Inc., Aurora, Ill.**

For more details circle #36 on mailing card.

Polyethylene Packaging Protects Hypodermic Needles

Monojet "200" luer-lock needles are now packaged in molded Tenite polyethylene to preserve sterility. The packaging consists of a sheathlike container and heat-sealed cap. Needle and package are gas sterilized at the factory after the cap is heat-sealed into place. Molded lugs on the inside of the container hold the needle securely to prevent touching the side walls. Individual containers are color-coded to gauge and marked in black with length and gauge information. After use the container may be slipped back over the needle for safe disposability. **Roehr Products, Deland, Fla.**

For more details circle #37 on mailing card.

Mashed Bananas Now Available in Cans

Pure mashed banana is available in canned form. A unique new aseptic process makes possible the preservation and standardization of the ripe banana flavor in this 100 per cent pure banana product. Made from choice bananas which are ripened and aseptically processed, Chiquita brand Mashed Bananas are available in bulk packs for institutional cooking. **American Home Foods, 22 E. 40th St., New York 16.**

For more details circle #38 on mailing card.

Caddy Carry-All Holds Maintenance Supplies

An accessory to the trash collecting Waste Mobile is now available for carrying maintenance supplies. The Caddy is a sturdy blue fabric carrier with three rows of roomy pockets tailored to accommodate polishes, cleaners, cloths, brushes and other maintenance tools. Designed to fit both the four and the six-bushel Waste Mobiles, the Caddy has ten pockets and a heavy quilted backing to prevent damage to supplies. It is attached to the Waste Mobile bar by four fasteners at the top and two elastic tape loops which slip over the casters onto the legs. The Caddy is quickly attached and stays on the Waste Mobile when in

use or when closed for storage. **Walton-March, 1592 Deerfield, Highland Park, Ill.**

For more details circle #39 on mailing card.

Low Sodium and Fat in Dietetic Cake

A sixty-day shelf life, plus low sodium, fat and carbohydrate content make the new LeRoy Packaged Dietetic Cake suitable for cardiac diets and also permits its inclusion in diabetic and weight control diets. The completely baked cake, wrapped in airtight polyethylene bags, is ready for immediate consumption when the package is open, and has the taste appeal of ordinary cake. **LeRoy Foods, Inc., 284 S. 5th St., Brooklyn 11, N.Y.**

For more details circle #40 on mailing card.

(Continued on page 226)

Pharmaceuticals

Chloromycetin Succinate

Broad coverage against disease-producing organisms as produced by other Chloromycetin products is available in a new injectable form called Chloromycetin Succinate. Studies indicate that the compound is rapidly absorbed by the patient, produces effective serum levels quickly and is easy to administrate intramuscularly, intravenously or subcutaneously. It is available in powdered form in vials for dilution before injection. **Parke, Davis & Co., Jos. Campau at the River, Detroit 32, Mich.**

For more details circle #41 on mailing card.

Ilosone Sulfa

Ilosone Sulfa is a combination of the antibiotic Ilosone with triple sulfas. It provides the advantage of Ilosone's rapid, high and prolonged blood levels with the support of triple sulfonamides for wider anti-infective action. It combats gram-positive and many gram-negative micro-organisms and is indicated in the treatment of mixed infections. It is supplied in scored, oblong tablets in bottles of 24 and 100. **Eli Lilly & Co., 740 S. Alabama, Indianapolis 6, Ind.**

For more details circle #42 on mailing card.

Urevert

Urevert is a new life-saving drug, combining sterile, lyophilized, synthetic urea and an invert sugar solution, for use in the treatment of head injuries and in brain surgery. Developed jointly by Dr. Manucher Javid of the University of Wisconsin and Baxter Laboratories, clinical tests have proved that Urevert can safely reduce increased intracranial pressure resulting from head injuries or brain tumors, thus facilitating treatment or surgery, and can be used advantageously before, during and after neurosurgery. The new product is packaged as a unit consisting of two containers for combination in solution for immediate infusion. **Baxter Laboratories, Inc., Travenol Laboratories Div., Morton Grove, Ill.**

For more details circle #43 on mailing card.

Lavema Enema Powder

Lavema is a new product in powder form, developed for use as a cleansing enema and as a radiopaque enema adjuvant. When added to an enema solution, it produces a moderate cathartic action on the colon by acting as a local stimulant on the mucous membrane of the large intestine for removal of any gas or feces in the large bowel. Extensive clinical studies were made to ensure its high level of effectiveness and safety. **Winthrop Laboratories, 1450 Broadway, New York 18.**

For more details circle #44 on mailing card.

Mornidine

Mornidine brand of pipamazine is a sugar-coated, rose-colored tablet for oral use in the prevention or control of nausea or vomiting. It is also available in ampul form for parenteral administration. It is indicated to prevent or stop nausea and vomiting associated with pregnancy, anesthesia, radiotherapy, nitrogen mustard therapy and gastroenteritis. **G. D. Searle & Co., P.O. Box 5110, Chicago 80.**

For more details circle #45 on mailing card.

Literature and Services

• Sixteen illustrations of Hospitality Group institutional china are shown in full color in a 12-page leaflet recently released by Syracuse China Corp., 1806 W. Fayette St., Syracuse, N.Y. "**The Story of Hospitality**" tells how this group of stock patterns, composed of a complete variety of shapes and decorations, was designed to meet the needs of every food service operation.

For more details circle #46 on mailing card.

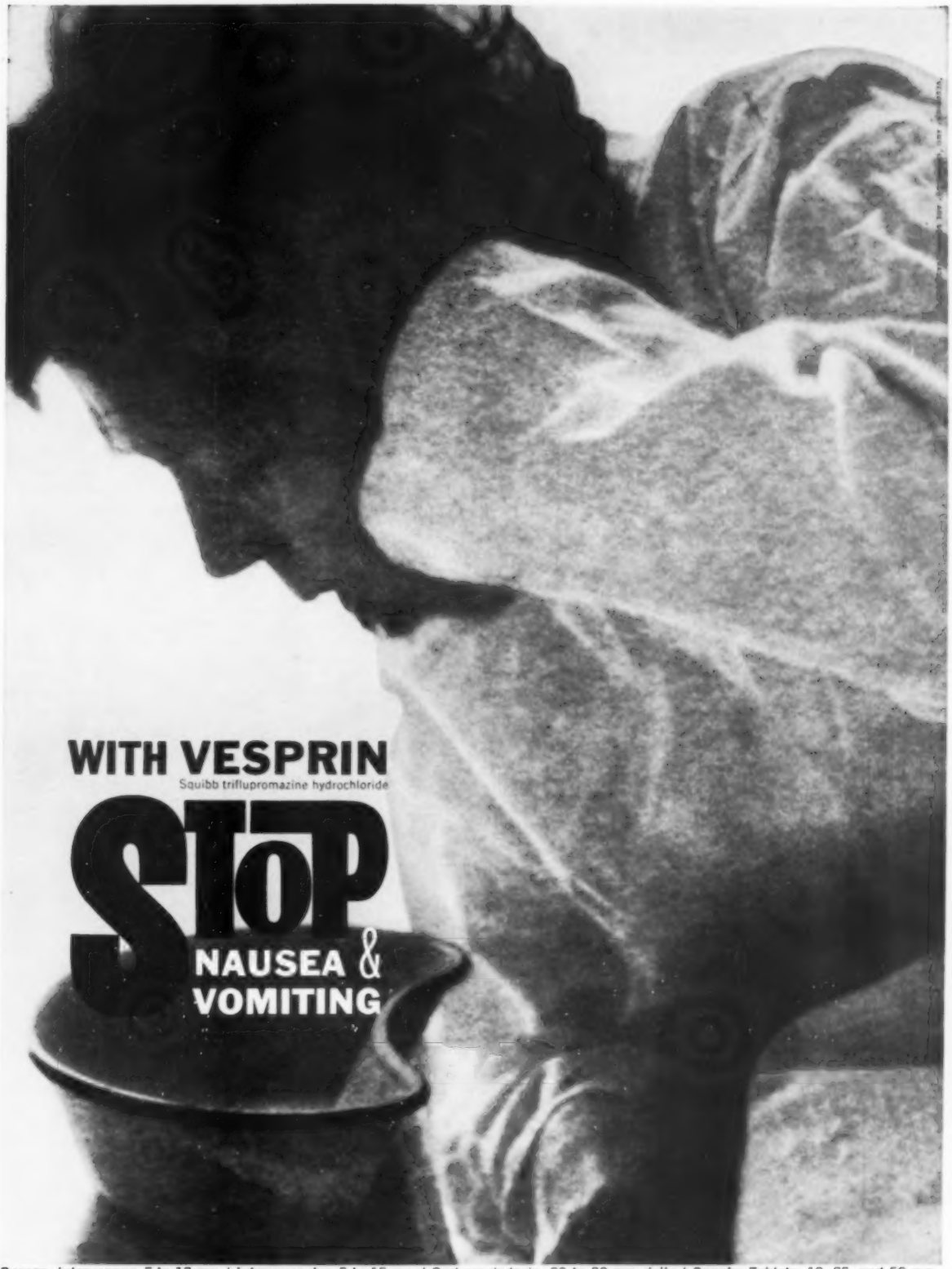
• Groups in and out of the hospital will find helpful information in the new motion picture, "**Hands We Trust,**" just released by the American College of Surgeons, 40 E. Erie St., Chicago 11. Portraying the successive steps in the training of a young surgeon, from his admission to medical school, through post graduate training, to final certification as a specialist and acceptance as a Fellow of the American College of Surgeons, the 30-minute film is designed to acquaint the public with the requirements the surgeon must meet to qualify in his specialty today.

For more details circle #47 on mailing card.

• "**How to Use and Care for Your Hubbert Steam-Jacketed Kettle**" is explained in a booklet published by B. H. Hubbert & Son, 1311 S. Ponca St., Baltimore 24, Md. Complete descriptive information on Hubbert steam-jacketed kettles, how they work, types available, cooking procedures and recipes for quantity cooking in these kettles are included.

For more details circle #48 on mailing card.

(Continued on page 228)



Dosage: Intravenous, 5 to 12 mg. / Intramuscular, 5 to 15 mg. / Oral prophylaxis, 20 to 30 mg. daily / **Supply:** Tablets, 10, 25, and 50 mg., bottles of 50 and 500 / Emulsion, 30-cc. dropper bottles and 120-cc. bottles (10 mg./cc.) / Parenteral Solution, 1-cc. multiple dose vial (20 mg./cc.) / 10-cc. multiple dose vial (10 mg./cc.) / Vesprin Injection Unimatic (15 mg. in 0.75 cc.)

Vesprin/the tranquilizer that fills a need in every major area of medical practice/ anxiety and tension states, pre- and postoperative tranquilization, alcoholism, and obstetrics.

SQUIBB

Squibb Quality—the Priceless Ingredient

• A new 16mm film **"Fire and Explosion Hazards From Flammable Anesthetics"** is available from Abbott Laboratories, North Chicago, Ill. Prepared jointly by the U.S. Bureau of Mines, the Department of Anesthesiology of Pittsburgh University Medical School and St. Francis General and Medical Center Hospitals in Pittsburgh, the film shows the role of static electricity in causing ignition by the use of a laboratory demonstration, animated drawing sequences and slow motion. Steps to eliminate each of the operating room hazards are shown.

For more details circle #49 on mailing card.

• **A diagnostic lamp identification chart,** published by the Medical Products Div., Schueler & Co., 75 Cliff St., New York 38, presents life-size illustrations of lamps for diagnostic instruments and facilitates quick identification of each lamp.

For more details circle #50 on mailing card.

• Specifications and general information on the K-17 floor machine are included in **"The Kent K-17"** booklet available from The Kent Co., Inc., Canal St., Rome, N. Y. Features such as the detachable solution tank, unbreakable gears, brushes and attachments are described.

For more details circle #51 on mailing card.

• **The Fiftieth Anniversary issue of Oakite News Service** traces the evolution of cleaning throughout history. The booklet, published by Oakite Products Corp., 19 Rector St., New York 6, is illustrated with drawings and photographs and includes a brief history of the company and its policies.

For more details circle #52 on mailing card.

• **"A Chemical Approach to Controlled Wash Pressure"** is discussed editorially in a 16-page booklet available from Economics Laboratory, Inc., 230 Park Ave., New York 17. It presents the results of studies of the two new commercial dishwashing compounds, Score and Event, in relation to machine wash pressure. Machine factors, chemical factors, laboratory apparatus, food soil studies, effect of rinse additives, studies of detergents present and apparatus studies, field studies and a wash new, effect of temperature, wash impact pressure survey are among the subjects covered by text and illustrations.

For more details circle #53 on mailing card.

• Current information on **Refrigeration Valves, Fittings and Supplies** available from the Frick Company, Waynesboro, Pa., is available in a new loose-leaf catalog. New items in the line are described and pictured and prices are included. Eight pages of useful tables on refrigerants, brines, steel pipe, copper and steel tubes, storage temperatures, mechanical equivalents and thermometer scales are also presented.

For more details circle #54 on mailing card.

• An **eight-page catalog** presenting data on refrigerated bases, self-contained service refrigerators and a hamburger dispenser is offered by The Bastian-Blessing Co., 4203 W. Peterson Ave., Chicago 46. The illustrated catalog shows how these units may be lined up to match the other food service equipment in the Bastian-Blessing line.

For more details circle #55 on mailing card.

• **"Laundry Equipment for Small, Medium, Large Hospitals"** is discussed in a brochure offered by American Laundry Machinery Co., Cincinnati 12, Ohio. Descriptive information and illustrations are used for each section, starting with the small hospital employing American Juniorette Laundry equipment and carrying on through every type of laundry equipment required for even the largest hospital laundry operations.

For more details circle #56 on mailing card.

• The nine major brands of fire extinguishing systems, portable extinguishers, cabinets and other interior fire control products manufactured by The Fyr-Fyter Co., 221 Crane St., Dayton 1, Ohio, are described in a new 28-page brochure, **Form No. S-62.** The comprehensive product and installation information guide is fully illustrated and provides data for architects, engineers, administrators and department heads concerned with the selection, purchase or installation of interior fire control equipment.

For more details circle #57 on mailing card.

• **Three aids for use in the rehabilitation of mastectomy patients** are available from Identical Forms, Inc., 17 W. 60th St., New York 23. A new brochure, "The Total Care of Your Mastectomy Patient," is an abridgement of Dr. Edward F. Lewison's text on "Breast Cancer, Its Diagnosis and Treatment." A complete teaching kit for classroom demonstration is another unit which, together with the Guide for the Individual Mastectomy Patient and the brochure on care, provides a time-saving series for rehabilitation. The "Guide" illustrates ten basic post-operative exercises and is written by a mastectomy patient.

For more details circle #58 on mailing card.

Suppliers' News

Glasco Products Company, 111 N. Canal St., Chicago 6, national distributor of hospital and surgical glassware and supplies, announces the dissolution of the company effective December 31, 1959. **Harlan Hobbs,** President, reports that the major volume of products distributed are manufactured by **Kimble Glass Company** which, like Glasco, is a subsidiary of **Owens-Illinois.** Intensive study reveals that such services can be handled by Kimble. Glasco will make every effort to assure an orderly changeover and dissolution without confusion for customers in the hospital field.

Mead Johnson & Company, Evansville 21, Ind., manufacturer of nutritional and pharmaceutical specialty products, announces the sale of the product line and business of its **Parenteral Division** for cash to the **American Hospital Supply Corp., Evanston, Ill.,** effective immediately.

Swivelier Co., Inc., 30 Irving Place, New York 3, manufacturer of adjustable lighting equipment, announces the relocation of its general offices and factory from the Bush Terminal area in Brooklyn to rural Nanuet, N. Y. The new modern one-story plant is designed for increased production, improved quality control and better operating conditions.

TO "WHAT'S NEW"

Pages 203-228

Key

20 Two-Person Steel Lockers
Penco Div., Alan Wood Steel Co.

21 Mobile Cup and Saucer Dispenser
American Machine & Foundry Co.

22 Simplo Lighting Fixture
Edwin F. Guth Co.

23 Specialty Needles
Hypo Surgical Supply Corp.

24 Tray Dispenser
Serv-O-Lift Corp.

25 Pneumatic Unit Ventilators
Valveblower Co. of Calif., Inc.

26 Velveton Floor Covering
E. I. duPont de Nemours & Co.

27 Lavamat Faucet
Kel-Win Mfg. Co.

28 D-70 Duplicator
Ditto, Inc.

29 Sole-Bond
Formica Corp.

30 "Scotchpak" for Cooking
Minnesota Mining & Mfg. Co.

31 Automatic Parking
Parcoa Div.

32 Vibroflotation System
The Raymond Engineering Co.

33 Penis Exit Device
Yale & Towne Mfg. Co.

34 Metal Cleanser
Bar-Ray Products, Inc.

35 All-Purpose Suspensoire
The Hayes Corp.

36 Double-Face Coat Rack
Lyon Metal Products, Inc.

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13	14	15	16	17	18	87	88	89	90	91	92	93	94	95	96	97	98	99	100
19	20	21	22	23	24	101	102	103	104	105	106	107	108	109	110	111	112	113	114
25	26	27	28	29	30	115	116	117	118	119	120	121	122	123	124	125	126	127	128
31	32	33	34	35	36	129	130	131	132	133	134	135	136	137	138	139	140	141	142
37	38	39	40	41	42	143	144	145	146	147	148	149	150	151	152	153	154	155	156
43	44	45	46	47	48	157	158	159	160	161	162	163	164	165	166	167	168	169	170
49	50	51	52	53	54	171	172	173	174	175	176	177	178	179	180	181	182	183	184
55	56	57	58			185	186	187	188	189	190	191	192	193	194	195	196	197	198
						199	200	201	202	203	204	205	206	207	208	209	210	211	212
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13	14	15	16	17	18	87	88	89	90	91	92	93	94	95	96	97	98	99	100
19	20	21	22	23	24	101	102	103	104	105	106	107	108	109	110	111	112	113	114
25	26	27	28	29	30	115	116	117	118	119	120	121	122	123	124	125	126	127	128
31	32	33	34	35	36	129	130	131	132	133	134	135	136	137	138	139	140	141	142
37	38	39	40	41	42	143	144	145	146	147	148	149	150	151	152	153	154	155	156
43	44	45	46	47	48	157	158	159	160	161	162	163	164	165	166	167	168	169	170
49	50	51	52	53	54	171	172	173	174	175	176	177	178	179	180	181	182	183	184
55	56	57	58			185	186	187	188	189	190	191	192	193	194	195	196	197	198
						199	200	201	202	203	204	205	206	207	208	209	210	211	212
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1. Humphries, R. E.: J. Invest. Dermat. **9**:219, (Nov.) 1947.
2. Peck, S. M., *et al.*: J. Invest. Dermat. **10**:367, (May) 1948.

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